L.A. Care
HEALTH PLAN

L.A. Care Health Plan
MEMBER HANDBOOK

DISCLOSURE FORM AND EVIDENCE OF COVERAGE

SOUTHERN CALIFORNIA REGION

July 1, 2012 through June 30, 2013

Kaiser Foundation Health Plan, Inc.

KAISER PERMANENTE®

This booklet tells you about your benefits, what is not covered, and how to get care. It also tells you how to solve problems. To get a copy of this booklet in Spanish, call our Member Service Call Center at **1-800-788-0616**, weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. (except holidays). To get a copy of this booklet in Chinese, call our Member Service Call Center at **1-800-757-7585**, weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. (except holidays). To get a copy of this booklet in Armenian, Cambodian, Farsi, Korean, Russian, Tagalog, or Vietnamese, call our Member Service Call Center at **1-800-464-4000**, weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. (except holidays). To get help in Armenian, Cambodian, Farsi, Korean, Russian, Tagalog, or Vietnamese, ask for an interpreter.

Este folleto le explica sus beneficios, lo que se excluye de la cobertura y cómo obtener atención médica. También le informa sobre cómo resolver problemas. Si desea un ejemplar de este folleto en español, llame a nuestro Centro de Llamadas para Servicios a los Miembros al **1-800-788-0616**, entre semana de 7 a.m. a 7 p.m. y los fines de semana de 7 a.m. a 3 p.m. (excepto días festivos).

這本手冊向您解釋應得的福利，說明如何獲得服務，並告訴您如何解決各種問題。如果您需要本手冊的漢語版本，請致電我們的會員服務電話中心：1-800-757-7585 。我們週一至週五早7時至晚7時、週末早7時至下午3時接聽您的電話（除節日之外）。

Այս գրքույկը ձեզ ասում է ձեր նպաստների, չծածկված բաների և խնամքը ինչպես ստանալու մասին: Այն նաև ձեզ ասում է խնդիրները ինչպես լուծելու մասին: Այս գրքույկի հայերեն օրինակը ստանալու համար զանգահարեք մեր Հաճախորդի Սպասարկման Հեռախոսակենտրոն **1-800-464-4000** համարով շաբաթամիջին՝ կ.ա. ժամի 7-ից մինչև կ.հ. ժամի 7-ը, և շաբաթավերջին՝ կ.ա. ժամի 7-ից մինչև կ.հ. ժամի 3-ը (բացի տոնական օրերից):

កូនសៀវភៅនេះប្រាប់អ្នកអំពីអត្ថប្រយោជន៍របស់អ្នក អ្វីៗដែលរ៉ាប់រង និងប្រាប់អំពីរបៀបទទួលការថែទាំ ។ វាក៏ប្រាប់អ្នកអំពីរបៀបដោះស្រាយបញ្ហាផ្សេងៗដែរ ។ ដើម្បីទទួលសំណៅចំឡុងនៃកូនសៀវភៅនេះជាភាសាខ្មែរ សូមទូរស័ព្ទទៅកន្លែងសេវាសមាជិករបស់យើង លេខ **1-800-464-4000** នៅថ្ងៃធ្វើការធម្មតា ពីម៉ោង 7 ព្រឹក ដល់ 7 ល្ងាច និងនៅចុងអាទិត្យ ពីម៉ោង 7 ព្រឹក ដល់ 3 រសៀល (លើកលែងតែថ្ងៃបុណ្យ) ។ ដើម្បីទទួលជំនួយជាភាសាខ្មែរ សូមស្នើសុំអ្នកបកប្រែម្នាក់ ។

این کتابچه اطلاعاتی را در مورد مزایای شما، خدمات تحت پوشش و نحوه دریافت مراقبت در اختیار شما قرار می دهد. همچنین اطلاعاتی را در مورد نحوه رفع مشکلات ارائه می کند. برای دریافت یک نسخه از این کتابچه به زبان فارسی، با مرکز تلفنی خدمات مشتری (Member Service Call Center) به شماره **1-800-464-4000** در روزهای هفته از ساعت 7 صبح تا 7 بعدازظهر و آخر هفته ها از ساعت 7 صبح تا 3 بعدازظهر (غیر از روزهای تعطیل) تماس بگیرید. برای دریافت کمک به زبان فارسی برای مترجم درخواست کنید.

이 안내서에는 보험 가입자님께서 어떤 의료 보험 혜택을 받을 수 있는지, 어떤 진료가 혜택 대상에서 제외되는지, 그리고 어떤 절차를 거쳐 진료를 받는지 등에 대한 설명이 나와 있습니다. 아울러, 문제 해결 방법도 나와 있습니다. 한국어로 된 안내서를 받아보시려면, 주중에는 오전 7시부터 오후 7시까지 사이에, 그리고 주말(단, 국경일은 휴무)에는 오전 7시부터 오후 3시까지 사이에 저희 보험 가입자 서비스 센터 **1-800-464-4000** 번으로 전화시면 됩니다. 필요하시면, 한국어 통역을 부탁하셔도 됩니다.

В этой брошюре говорится о полагающихся вам льготах, о том, что не покрывается, а также от том, как вы можете получить помощь. Из нее вы также узнаете о том, как разрешать возникающие проблемы. Если вы хотите получить экземпляр этой брошюры на русском языке, позвоните в наш Центр вызовов для участников по телефону **1-800-464-4000**. Вы можете звонить в Центр по рабочим дням с 7 утра до 7 вечера, а по выходным с 7 утра до 3часов дня (за исключением праздников). Если вы нуждаетесь в помощи на русском языке, попросите предоставить вам переводчика.

Ang librito na ito ay nagbibigay sa inyo ng impormasyon tungkol sa inyong mga benepisyo, kung ano ang hindi sinasaklaw, at kung paano makakakuha ng pangangalaga. Sinasabi rin nito sa inyo kung paano lulutasin ang mga problema. Upang makakuha ng kopya ng librito na ito sa Tagalog, tawagan ang aming Member Service Call Center sa **1-800-464-4000,** Lunes hanggang Biyernes mula 7 ng umaga hanggang 7 ng gabi at Sabado't Linggo mula 7 ng umaga hanggang 3 ng hapon (maliban kung piyesta opisyal). Upang makakuha ng tulong sa Tagalog, humingi ng isang interpreter o tagapagsalin.

Tập sách nhỏ này cho biết về quyền lợi của quý vị, những gì không được bao trả, và cách thức để được chăm sóc sức khỏe. Sách này còn cho biết cách để giải quyết nhiều vấn đề. Nếu muốn tập sách này bằng tiếng Việt, xin gọi cho Trung Tâm Trả Lời của Dịch Vụ Hội Viên (Member Service Call Center) tại số **1-800-464-4000**, trong tuần 7:00 sáng đến 7:00 tối và cuối tuần từ 7:00 sáng đến 3:00 chiều (ngoại trừ ngày lễ). Để được giúp đỡ bằng tiếng Việt, xin yêu cầu một thông dịch viên.

2012 Summary of Changes and Clarifications

Each year we tell you about changes to your *Medi-Cal* coverage.

- The most important changes are listed in this summary.
- Please read the entire *Member Handbook* to learn more about these changes.
- Note that some sections of the *Member Handbook* are in different order than they were last year.

Changes

L.A. Care grievance process

The *L.A. Care* mailing address for filing *grievances* is:

L.A. Care Health Plan
1055 W. 7th St., 10th Floor
Los Angeles, CA 90017

Hospice care

We have clarified that children under the age of 21 may choose to continue to get treatment for their illness while receiving hospice care.

Clarifications

Ambulance s*ervices* (pending regulatory approval)

We have revised the description of coverage for emergency ambulance *services* as follows:

We cover *services* of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an *emergency medical condition* that required ambulance *services*.
- Your treating physician determines that you must be transported to another facility because your *emergency medical condition* is not *stabilized* and the care you need is not available at the treating facility.

Emergency services

We have replaced the term "Emergency Care" with "Emergency Services," and have revised the definitions of "*emergency services*," "*emergency medical condition*," and "s*tabilize*." Also, we have revised the definition of "*emergency medical condition*" in accord with

California Assembly Bill 235 to indicate that a mental health condition is an *emergency medical condition* when it meets the requirements of the definition under PPACA, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others.
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Helpful information

The "How to Reach Us" section has been revised and updated, and includes additional information about available resources and phone numbers.

Emergency Services and *Urgent Care*

The Plan has revised the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Provider" section. This section has been renamed to "*Emergency Services* and *Urgent Care*" and describes how to obtain *emergency services* and *urgent care* from both plan providers and non-plan providers.

Also, "*Post-stabilization care*" is now a subheading under "*Emergency Services*."

Kaiser Permanente service area

We have revised the definition of "*Kaiser Permanente service area*" for clarity. The ZIP codes that are in the "*Kaiser Permanente service area*" for each county are now listed, even when the entire county is inside the "*Kaiser Permanente service area*". For each county, we now say whether all ZIP codes in the county are inside the "*Kaiser Permanente service area*" or whether only the ZIP codes that are listed are inside the "*Kaiser Permanente service area*".

Testicular implants

We have clarified that testicular implants implanted as part of a covered reconstructive surgery is covered.

Table of Contents

About This Member Handbook

L.A. Care Health Plan

Thank you for choosing *Kaiser Foundation Health Plan, Inc.,* as your plan partner through *L.A. Care Health Plan* (*L.A. Care*), a public entity serving Los Angeles County. This *Member Handbook* tells you about most health care coverage you get through *Kaiser Permanente*. It is good from July 1, 2012, through June 30, 2013.

Some words in *italics* have special meaning in this *Member Handbook*. A list of these words is in the "Terms You Should Know" section. In this *Member Handbook*, "we" or "us" means *Kaiser Foundation Health Plan, Inc.,* and "you" means a *member*.

This *Member Handbook* is only a summary of your health care coverage. Your health coverage is determined by our contract with *L.A. Care.*

Please read the following information so that you will know from whom or what group of providers you may get health care and what your health care coverage is. If you have special health care needs, please carefully read the sections that apply to you.

Kaiser Permanente

Kaiser Permanente provides *services* to you through *Kaiser Foundation Health Plan, Inc.*, *Kaiser Permanente plan hospitals*, and the *Medical Group.* They work together to give you quality care. When you choose *Kaiser Permanente,* you are choosing to get your care through our medical care program. You can get all the covered *services* you need. These *services* include *routine care* with your *Kaiser Permanente plan doctor*, *hospital inpatient care,* lab tests, drugs, *emergency services, urgent care,* and other *services* listed in the "Benefits" section. We also offer *health education* programs that help you protect and improve your health.

You must get most *services* from *Kaiser Permanente plan providers* in the *Kaiser Permanente service area*. The only *services* you can get from *non–Kaiser Permanente plan providers* are:

- Care at a *Federally Qualified Health Center (FQHC).*
- Care at an *Indian Health Center.*
- Covered emergency ambulance *services.*
- Covered *emergency services* and *post-stabilization care.*
- Covered *family planning services.*
- Covered *out-of-area urgent care.*
- *Referrals* to *non–Kaiser Permanente plan providers.*
- Some covered *sensitive services.*

How to Get Help

Getting Help from Kaiser Permanente

We want you to be happy with the health care you get from *Kaiser Permanente*. If you have any questions or concerns about your care, talk with your *PCP* (*Primary Care Provider*) or other *Kaiser Permanente plan providers* who are treating you. They want to help you with your questions.

Our Member Services staff can answer questions about your benefits. They can tell you where you can get *services* and what *services* are covered at each *Kaiser Permanente plan facility.* They can also tell you how to set up a time to see your doctor.

If you need a copy of *Your Guidebook to Kaiser Permanente Services* (*Your Guidebook*), our Member Services staff can send it to you. They can also help you with any problems listed in the "How to Solve Problems" section.

Member Services Offices

Many *Kaiser Permanente plan facilities* have an office with staff who can help you get *services*. These offices may be called Member Services, Patient Assistance, or Customer Service.

The Member Services offices in your area are:

Baldwin Park
Baldwin Park Medical Center
1011 Baldwin Park Blvd.

Bellflower
Bellflower Medical Center
9400 E. Rosecrans Ave.

Downey
Downey Medical Center
9333 Imperial Hwy.

Orchard Medical Offices
9499 E. Imperial Hwy.

Harbor City
South Bay Medical Center
25825 S. Vermont Ave.

Lancaster
Lancaster/Antelope Valley Medical Offices
43112 N. 15th St. W.

Los Angeles
Los Angeles Medical Center
1505 Edgemont St.,
4950 Sunset Blvd., and
1515 N. Vermont Ave.

West Los Angeles Medical Center
6041 Cadillac Ave.

Palmdale
Palmdale/Antelope Valley Medical Offices
4502 E. Avenue S.

Panorama City
Panorama City Medical Center
13652 Cantara St.

Woodland Hills
Woodland Hills Medical Center
5601 De Soto Ave.

Look in *Your Guidebook* to find other Member Services offices.

Member Service Call Center

You can call our Member Service Call Center toll free weekdays 7 a.m.–7 p.m., weekends 7 a.m.–3 p.m. (except holidays):

- English **1-800-464-4000**
- Spanish..... **1-800-788-0616**
- Chinese dialects..... **1-800-757-7585**
- TTY **1-800-777-1370**

If you need help in other languages, you can ask for an *interpreter*. Call our Member Service Call Center toll free at **1-800-464-4000**.

To talk to a licensed health care professional, or for *urgent care* needs after hours, please call the advice phone number. See "Not Sure What Kind of Care You Need?" section for the phone number to call.

Website

You can contact Member Services by going online at **kp.org**.

Your Guidebook to Kaiser Permanente Services

Your Guidebook tells you how to get *services,* how to see a doctor, and what *services* are covered at each *Kaiser Permanente plan facility* in your area. We update *Your Guidebook* from time to time. If you would like a copy, call our Member Service Call Center or go online at **kp.org.**

Interpreter Services

If you do not speak English well, we can help you. When you come in or call for an appointment, tell us if you want an *interpreter*. If one of our trained staff does not speak your language, we can provide *interpreter* services in person or by phone. Each *Kaiser Permanente plan facility* has *interpreter* services, including sign-language *interpreters*. You can get this help anytime (24 hours a day, seven days a week). There is no cost to you. You do not have to use a family member or friend as an *interpreter.*

Getting Help from *L.A. Care*

If you have questions about *L.A. Care*, you can call the plan toll free anytime at **1-888-4LA-CARE** (**1-888-452-2273**).

Telephone Access (TTY)

Members with hearing or speech loss who have a text telephone device (TTY, also known as TDD) can use the California Relay Service if there is no TTY number for your call. To use the California Relay Service, call **711**.

Your Rights and Responsibilities

Your Rights

You have the right to:

- Take part in deciding about your care.
- Hear about all your care options. You can refuse a treatment if you do not agree with it or if it conflicts with your beliefs.
- Tell us what kind of care you want if you are very ill in the future.
- See your *protected health information* (*PHI*). We will not let anyone else see your *PHI* without your consent, except as allowed by law.
- Know the names of the people who provide your care and what kind of training they have.
- Have an *interpreter* who speaks your language at no cost to you.
- Get care with dignity and respect for your cultural background, personal preferences, and values.
- Have impartial access to care.
- Know that the care you get will be private and confidential.
- Get care in a place that is safe, secure, clean, and accessible.
- Choose a *PCP (Primary Care Provider)* and change your *PCP* at any time for any reason.
- Get a second opinion from a *Kaiser Permanente plan doctor* at any time.
- Know how to get help and solve problems. Your care will not be affected if you file a *grievance* or ask for a *state hearing*.

As a *Medi-Cal member*, you also have the right to:

- Change plan partners at any time.
- Get some *services* covered from *non–Kaiser Permanente plan providers* without a *referral* or *authorization* as described in this *Member Handbook*.
- Ask for and get translated documents that provide important information on how to get and use *services,* including:
  - this *Member Handbook;*
  - *Your Guidebook to Kaiser Permanente Services;*
  - form letters (such as denial letters and Emergency Department follow-up letters);
  - reminder notices for appointments, shots, initial health examinations, and prenatal care follow-up;
  - member surveys;
  - member newsletters.

Your Responsibilities

You are responsible for:

- Reading this *Member Handbook* to learn what coverage you have and how to get *services.*
- Using your ID cards properly. Bring your *Kaiser Permanente* ID card, a photo

ID, and your *Medi-Cal* ID card with you when you come in for care.

- Keeping appointments.
- Telling your *PCP* (*Primary Care Provider*) about your health and health history.
- Following the care plan you and your *PCP* agree on.
- Recognizing the effect of your lifestyle on your health.
- Being considerate of *Kaiser Permanente plan doctors*, other health care staff, and *members*.
- Paying for *services* that are not covered by *Medi-Cal*.
- Solving problems using the ways described in this *Member Handbook*.
- Telling us if you are admitted to a *non–Kaiser Permanente plan hospital*.

See *Your Guidebook* for more information on your rights and responsibilities.

Terms You Should Know

Some terms in *italics* have special meaning in this *Member Handbook*. When we use a term with special meaning in only one section of this *Member Handbook*, we will tell you the meaning in that section. The terms in this "Terms You Should Know" section have special meaning when italicized and used in any section of this *Member Handbook*. This section tells you the meaning of these terms. This section does not describe coverage.

Acute: A health condition that is sudden and lasts a limited duration.

Allowance: A credit that you can use to pay for an item. If the price of the item(s) you choose is more than the *allowance*, you will pay the amount that is more than the *allowance*.

Appropriately qualified medical professional: A licensed provider who is acting within his or her scope of practice and who has the clinical background to treat the illness or condition.

Authorize: Give written approval for *services*.

Bariatric surgery: A kind of major surgery to treat severe obesity.

Binding arbitration: A way to solve problems using a neutral third party. For problems that are settled through *binding arbitration,* the third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial.

California Children's Services (CCS): A program that covers *services* for people up to age 21 with certain health problems.

California Department of Health Care Services (DHCS): The state office that oversees the *Medi-Cal* program.

California Department of Managed Health Care (DMHC): The state office that oversees managed care health plans.

Certified nurse midwife: A registered nurse certified as a nurse midwife by the California Board of Registered Nursing who attends cases of normal childbirth and provides care for mothers before, during, and after pregnancy, and for the newborn right after birth. A *nurse midwife* works under the direction of a *Kaiser Permanente plan doctor*.

Chemical dependency services: Certain *medically necessary services* for alcohol or drug abuse. Coverage for *chemical dependency services* is described under "*Chemical Dependency Services*" in the "Benefits" section.

Child Health and Disability Prevention Program: A program that covers checkups and shots (immunizations) for people up to age 21.

Chronic: A health condition that is long term and ongoing.

Clinical trial: A study to find out if a new treatment is effective. Coverage for *services* related to a *clinical trial* is described under "*Services* Related to *Clinical Trials*" in the "Benefits" section.

Copay: The amount you must pay when you get covered *services*. Covered *services* under this *Member Handbook* are provided at **no charge.**

Durable medical equipment (DME): Certain *medically necessary* equipment that:

- Can withstand repeated use
- Is used for a medical purpose
- Is generally not useful to someone who is not ill or hurt

Coverage for *durable medical equipment* is described under "*Durable Medical Equipment*" in the "Benefits" section.

Emergency contraceptive: A drug that can keep you from getting pregnant if your regular contraceptive fails or if you have had unprotected sex.

Emergency medical condition: A medical condition manifesting itself by *acute* symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an *Emergency Medical Condition* when it meets the requirements of the paragraph above, or when the condition manifests itself by *acute* symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an *Emergency Medical Condition*:

- A medical screening exam that is within the capability of the Emergency Department of a hospital, including ancillary *services* (such as imaging and laboratory *services*) routinely available to the Emergency Department to evaluate the *Emergency Medical Condition*
- Within the capabilities of the staff and facilities available at the hospital, *Medically Necessary* examination and treatment required to S*tabilize* the patient (once your condition is

Stabilized, *Services* you receive are *Post-Stabilization Care* and not *Emergency Services*)

Exclusion: A *service* that we do not cover.

Experimental or investigational: A *service* that we, with input from the *Medical Group*, find:

- Is not seen as safe and effective by generally accepted medical standards to treat a condition (even if it has been authorized by law for use in testing or other studies on human patients), or
- Has not been approved by the government to treat a condition

Family planning services: Certain *medically necessary services* that prevent or delay pregnancy. Coverage for *family planning services* is described under "*Family Planning Services*" in the "Benefits" section.

FDA (Food and Drug Administration): The federal agency that approves drugs and devices for use in health care.

Federally Qualified Health Center (FQHC): A clinic that gets federal funds to provide health care in a place that does not have a lot of health care providers.

Formulary: A list of drugs or items that have been approved for *members* who meet certain criteria.

Grievance: A formal process that is used to solve problems.

Health Care Options: The state program that enrolls and disenrolls *members*.

Health education: Programs that can help you learn how to protect and improve your health. Coverage for *health education* is described under "*Health Education*" in the "Benefits" section.

Hospital inpatient care: *Services* that you get when you are admitted to a *Kaiser Permanente plan hospital*. Coverage for *hospital inpatient care* is described under "*Hospital Inpatient Care*" in the "Benefits" section.

Independent medical review (IMR): A review process that is managed by the *California Department of Managed Health Care*.

Indian Health Center: A clinic that gets federal funds to provide health care to Native Americans.

Interpreter: Someone who converts a spoken message from one language to another.

Kaiser Foundation Health Plan, Inc.: A California nonprofit corporation. In this *Member Handbook*, "we" or "us" means *Kaiser Foundation Health Plan, Inc.*

Kaiser Permanente: *Kaiser Foundation Health Plan, Inc.*, Kaiser Foundation Hospitals (a California nonprofit corporation), and the *Medical Group*.

Kaiser Permanente plan doctor: A doctor who works for the *Medical Group*. Also, a doctor who contracts to provide *services* to *members*. This does not include doctors who contract only for referral *services*.

Kaiser Permanente plan facility: Any facility listed in the "Kaiser Permanente Plan Facilities" section or in one of the *Guidebooks* for the *Kaiser Permanente service area*. The list of *Kaiser Permanente plan facilities* in this *Member Handbook* is up-to-date as of July 1, 2012. If you have any questions about the current locations of *Kaiser Permanente plan facilities,* call our Member Service Call Center.

Kaiser Permanente plan hospital: Any hospital listed in the "Kaiser Permanente Plan Facilities" section or in one of the *Guidebooks* for the *Kaiser Permanente service area*. The list of *Kaiser Permanente plan hospitals* in this *Member Handbook* is up-to-date as of July 1, 2012. If you have any questions about the current locations of *Kaiser Permanente plan hospitals,* call our Member Service Call Center.

***Kaiser Permanente plan medical office*:** Any medical office listed in the "Kaiser Permanente Plan Facilities" section or in one of the *Guidebooks* for the *Kaiser Permanente service area*. The list of *Kaiser Permanente plan medical offices* in this *Member Handbook* is up-to-date as of July 1, 2012. If you have any questions about the current locations of *Kaiser Permanente plan medical offices,* call our Member Service Call Center.

Kaiser Permanente Plan Optical Sales Office: An optical sales office owned and operated by *Kaiser Permanente* or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of *Kaiser Permanente Plan Optical Sales Offices* in your area, except that *Kaiser Permanente Plan Optical Sales Offices* are subject to change at any time without notice. For the current locations of *Kaiser Permanente Plan Optical Sales Offices*, please call our Member Service Call Center.

Kaiser Permanente plan optometrist: A *Kaiser Permanente plan provider* who provides eye exams.

Kaiser Permanente plan pharmacy: Any pharmacy owned and operated by *Kaiser Permanente,* or another pharmacy we designate. See *Your Guidebook to Kaiser Permanente Services* for a list of *Kaiser Permanente plan pharmacies* in your area. If you have any questions about the current locations of *Kaiser Permanente plan pharmacies,* call our Member Service Call Center.

Kaiser Permanente plan provider: A *Kaiser Permanente plan hospital, Kaiser Permanente plan doctor,* the *Medical Group, Kaiser Permanente plan pharmacy,* or other health care provider that we designate as a *Kaiser Permanente plan provider*. This does not

include providers who contract only for *referral services*.

Kaiser Permanente plan skilled nursing facility: A *skilled nursing facility* approved by us.

Kaiser Permanente service area: The ZIP codes below for each county are inside the *Kaiser Permanente service area:*

- **Los Angeles:** All ZIP codes except 90704 are inside the *Kaiser Permanente service area*: 90001–84, 90086–91, 90093–96, 90099, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599;
- **Orange:** All ZIP codes in Orange County are inside the *Kaiser Permanente service area*: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899;
- **Riverside:** The following ZIP codes in Riverside County are inside the *Kaiser Permanente service area***:** 91752, 92220, 92223, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83;
- **San Bernardino:** The following ZIP codes in San Bernardino County are inside the *Kaiser Permanente service area***:** 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350,

92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880;

- **San Diego:** The following ZIP codes in San Diego County are inside the *Kaiser Permanente service area***:** 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–93, 92195–99;
- **Ventura:** The following ZIP codes in Ventura County are inside the *Kaiser Permanente service area***:** 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252.

Keep in mind:

- Coachella Valley and western Ventura County are not part of the *Kaiser Permanente service area* for *Medi-Cal members*. The only care you can get from *Kaiser Permanente plan providers* in these areas is *emergency services* or *out-of-area urgent care*.
- ZIP codes are subject to change by the U.S. Post Office.

***L.A. Care* (*L.A. Care Health Plan*):** Your *Medi-Cal managed care* health plan. *Kaiser Permanente* is your plan partner through *L.A. Care Health Plan*.

L.A. Care service area: Los Angeles County.

Limitation: A limit to a *service* that we cover.

Medi-Cal: A health care program that is paid for by state and federal funds.

Medi-Cal managed care: A *Medi-Cal* program where the state pays health plans a fixed fee for *services* that the plan provides to *members*.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medical transportation: Transport that is *medically necessary*. Coverage for *medical transportation* is described under "Medical Transportation" in the "Benefits" section.

Medically necessary: *Services* that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to relieve severe pain, through the diagnosis or treatment of disease, illness, or injury.

For *members* under the age of 21, *medically necessary* also means *services* to correct or improve defects, physical and mental illnesses, and conditions found by a health

care provider acting within the scope of his or her practice.

Medicare: A health care program that is paid for by federal funds.

Member: A person who is enrolled with us through *L.A. Care*. In this *Member Handbook,* "you" means a *member*.

Member Handbook: A booklet that tells you about your benefits, what is not covered, and how to get care. It also tells you how to solve problems. This *Member Handbook* is your *Disclosure Form and Evidence of Coverage*.

Non–Kaiser Permanente plan doctor: A doctor other than a *Kaiser Permanente plan doctor*.

Non–Kaiser Permanente plan hospital: A hospital other than a *Kaiser Permanente plan hospital*.

Non–Kaiser Permanente plan provider: A provider other than a *Kaiser Permanente plan provider*.

Nurse practitioner: A registered nurse who has additional training to do some things that doctors do. A *nurse practitioner* works under the direction of a *Kaiser Permanente plan doctor*.

Occupational therapy: *Medically necessary services* to help someone who is injured or disabled keep doing, or get better at, activities of daily living. Coverage for *occupational therapy* is described under "*Hospital Inpatient Care*," "*Outpatient Care*," "Hospice Care," and "Skilled Nursing/Intermediate/Subacute Facility Care" in the "Benefits" section.

Ombudsman: Someone who works for the *California Department of Health Care Services* and helps answer questions and solve problems.

Orthotic devices: *Medically necessary* items that support or correct a body part. Coverage for *orthotic devices* is described under "*Prosthetic Devices* and *Orthotic Devices*" in the "Benefits" section.

Ostomy supplies: *Medically necessary* supplies that take waste out of the body. Coverage for *ostomy supplies* is described under "*Ostomy Supplies* and *Urological Supplies*" in the "Benefits" section.

Out-of-area urgent care: *Medically necessary services* that you get to keep your health (or your unborn child's health) from seriously worsening due to an unexpected illness, unexpected injury, or unexpected complication of an existing condition (including pregnancy) if:

- You are temporarily outside the *Kaiser Permanente service area.*
- You reasonably believed that your (or your unborn child's) health would seriously worsen if care was delayed until you returned to the *Kaiser Permanente service area.*

Outpatient care: *Medically necessary services* that you get in a *Kaiser Permanente plan medical office* or in a *Kaiser Permanente plan hospital* when you have not been admitted to the hospital. Coverage for *outpatient care* is described under "*Outpatient Care*" in the "Benefits" section.

PCP (Primary Care Provider): Your *Kaiser Permanente plan doctor* or *nurse practitioner*.

Pharmacy services: *Medically necessary* drugs, supplies, and supplements. Coverage for *pharmacy services* is described under "Outpatient *Pharmacy Services*" in the "Benefits" section.

Physical therapy: *Medically necessary services* that use exercises and hands-on care to help someone who is sick or hurt keep or improve function. Coverage for *physical therapy* is described under "*Hospital Inpatient Care*," "*Outpatient Care*," "Hospice Care," and "Skilled Nursing/Intermediate/Subacute Facility Care" in the "Benefits" section.

Post-stabilization care: *Medically necessary services* related to your *emergency medical condition* that you get after the doctor who is treating you finds that your condition is *stabilized*.

Prosthetic devices: *Medically necessary* items that replace all or part of an organ or limb. Coverage for *prosthetic devices* is described under "*Prosthetic Devices* and *Orthotic Devices*" in the "Benefits" section.

Protected health information (PHI): Health facts that include your name, address, or something else that reveals who you are.

Reconstructive surgery: *Medically necessary* surgery to correct or repair parts of the body that are not normal. Coverage for *reconstructive surgery* is described under "*Reconstructive Surgery*" in the "Benefits" section.

Reduction: When other sources must pay for a *service* that we cover.

Referral: The process used by a *Kaiser Permanente plan doctor* to arrange for *services* by a specialist or other provider.

Regional Center: A center that provides *services* to people with developmental disabilities.

Regular Medi-Cal (fee-for-service): A *Medi-Cal* program where the state pays providers a fee based on the *services* they provide.

Respiratory therapy: *Medically necessary services* that help with breathing. Coverage for *respiratory therapy* is described under "*Hospital Inpatient Care*," "Hospice Care," and "Skilled Nursing/Intermediate/Subacute Facility Care" in the "Benefits" section.

Routine care: *Medically necessary services* that are not urgent.

Sensitive services: *Medically necessary services* for family planning, STDs (sexually transmitted diseases), HIV/AIDS, sexual assault, and abortions. Coverage for *sensitive services* is described under "*Family Planning Services*" and "*Sensitive Services*" in the "Benefits" section.

Services: Health care services or items ("health care" includes both physical health care and mental health care).

Short-Doyle mental health services: Certain *medically necessary services* for severe *chronic* mental illness that may require long-term hospitalization.

Skilled nursing facility: A facility that provides 24-hours-a-day skilled nursing care. The facility must provide inpatient skilled nursing care, rehabilitation *services*, or other related health *services,* and be licensed by the *California Department of Health Care Services* and meet *Medi-Cal* and *Medicare* standards. The term "*skilled nursing facility*" does not mean nursing home, rest home, or facility for the aged, if the facility provides mostly custodial care, including training in activities of daily living. Coverage for *skilled nursing facility services* is described under "Skilled Nursing/Intermediate/Subacute Facility Care" in the "Benefits" section.

Specialty mental health services: Certain *medically necessary outpatient care* or *hospital inpatient care* that you get from a mental health care specialist such as a psychologist or psychiatrist. To learn how to get *specialty mental health services,* see "Mental Health *Services*" in the "Benefits" section.

Speech therapy: *Medically necessary services* to help someone speak or swallow better. Coverage for *speech therapy* is described under "*Hospital Inpatient Care*," "*Outpatient Care*," "Hospice Care," and "Skilled Nursing/Intermediate/Subacute Facility Care" in the "Benefits" section.

Stabilize: To provide the medical treatment of the *Emergency Medical Condition* that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

State hearing: A way to solve a problem if you think a decision to deny, change, or delay *services* is wrong. In this process, you present your case to the state.

Urgent care: *Medically necessary services* that are needed promptly but are not an *emergency medical condition*. Coverage for *urgent care* from *non–Kaiser Permanente plan providers* is described in the "Emergency Services and Urgent Care" section.

Urological supplies: *Medically necessary* supplies that capture urine outside the body. Coverage for *urological supplies* is described in "*Ostomy Supplies* and *Urological Supplies*" in the "Benefits" section.

Your Guidebook to Kaiser Permanente Services: *Your Guidebook* describes the types of covered *services* that are available from each *Kaiser Permanente plan facility*, because some facilities provide only specific types of covered *services*. Also, it explains how to use our *services* and make appointments, and includes a detailed telephone directory for appointments and advice.

Your Guidebook is subject to change and is updated from time to time. You can get a copy by calling our Member Service Call Center or by going online at **kp.org.**

Who Can Enroll

Who Can Enroll in This Plan

To enroll with *Kaiser Permanente* through *L.A. Care*:

- You must live in the *L.A. Care service area*; and
- You must live in the *Kaiser Permanente service area*; and
- You must qualify for coverage under this plan; and
- We must be taking new *members.*

To learn more, call *L.A. Care* Member Services toll free at **1-888-839-9909**.

Note: If your membership with *Kaiser Permanente* ended for cause, you may not be able to enroll with us. If your membership ended for cause, we can ask *L.A. Care* to transfer you to a different plan partner. See "Reassignment for Cause" in the "How Your Coverage Can End" section to learn how someone can lose his or her coverage for cause.

How to Enroll

We do not enroll *members* directly. To enroll, call *L.A. Care* Member Services toll free at **1-888-839-9909** and let them know you want *Kaiser Permanente* as your plan partner.

How to Enroll a New Baby

We cover a new baby for the month of birth plus the next month. (If you have your baby the month before you become a *member*, we cover the baby for one month.) After that, your baby must have his or her own coverage.

It is important to get your new baby on *Medi-Cal* as soon as you can. After you have your baby, call your county eligibility worker right away to get your baby on *Medi-Cal.* It will take some time for your baby's coverage to start after you talk to your county eligibility worker. Let *L.A. Care* know you want *Kaiser Permanente* as your baby's plan partner.

How to Know When Your Coverage Starts

It takes up to 45 days for your *Kaiser Permanente* coverage to start after you let *L.A. Care* know you want *Kaiser Permanente* as your plan partner. *L.A. Care* will tell you in writing the date that your *Kaiser Permanente* coverage starts. Your *Kaiser Permanente* coverage starts on the first day of the month. To learn more, call *L.A. Care* Member Services toll free at **1-888-839-9909**.

Completion of Services for New *Members*

If you are getting *services* from a *non–Kaiser Permanente plan provider* when you enroll, you may be able to keep getting *services* from that provider through *regular Medi-Cal*.

To qualify, you must have a complex medical condition, such as pregnancy, organ transplant, *chronic* kidney dialysis, HIV/AIDS, cancer, or major surgery.

You cannot disenroll and get *services* from your old provider through *regular Medi-Cal* if:

- You have been enrolled with *L.A. Care* longer than 90 days; or
- Your treatment started after you enrolled with *L.A. Care*; or
- Your old provider contracts with *L.A. Care*.

To keep getting *services* through *regular Medi-Cal*, you must get approval from *DHCS*. Your doctor must fill out a medical exemption form. To learn more, call *Health Care Options* toll free at **1-800-430-4263.**

How to Get Care

Kaiser Permanente provides *services* to *members* through *Kaiser Foundation Health Plan, Inc.*, *Kaiser Permanente plan hospitals*, and the *Medical Group*. They work together to provide you with quality care. Through our medical care program, you can get all the covered *services* you need. These *services* include *routine care* with your own *Kaiser Permanente plan doctor*, *hospital inpatient care*, lab tests, *pharmacy services*, and other *services* listed in the "Benefits" section. You must get most *services* that we cover from *Kaiser Permanente plan providers* in the *Kaiser Permanente service area*.

Your PCP (*Primary Care Provider*)

A *PCP* is your *Kaiser Permanente plan doctor* or *nurse practitioner*. Your *PCP* provides well care and care when you are sick or hurt. Your *PCP* also helps to arrange *services* for *chronic* problems like asthma or diabetes, *referrals*, and hospital stays.

To Choose a PCP or Change to a New PCP

You should choose a *PCP* as soon as you join our plan. If you do not choose a *PCP* within 30 days, we will choose a *PCP* for you. You can change to a new *PCP* at any time for any reason. The process for choosing a *PCP* or changing to a new *PCP* is the same.

You can choose any available *PCP* from adult medicine, family medicine, and pediatrics. Also, women can choose any available *PCP* from Obstetrics/Gynecology (Ob/Gyn); this department is sometimes called Women's Health. The *PCP* you choose must be taking new patients.

You must choose a *PCP* at a *Kaiser Permanente plan facility* in one of the cities listed below (see the "Kaiser Permanente Plan Facilities" section for addresses of these facilities). To choose a *PCP,* call toll free **1-888-956-1616** (TTY users call **711**) and ask which *PCP*s are taking new patients. We can help match you with a *PCP* who knows your language or culture. A list of *PCP*s is online at **kp.org**.

Tri-Central Area

- Baldwin Park
- Bellflower
- Cudahy
- Diamond Bar
- Downey
- Gardena
- Harbor City
- Long Beach
- Lynwood
- Montebello
- San Dimas
- Torrance
- West Covina
- Whittier

Metro Los Angeles Area

- Culver City
- Glendale

- Inglewood
- Los Angeles (Los Angeles Medical Center, West Los Angeles Medical Center, East Los Angeles Medical Offices, Culver Marina Medical Offices)
- Pasadena

Valleys Area

- Lancaster
- Mission Hills
- Palmdale
- Panorama City
- Santa Clarita
- Simi Valley
- Thousand Oaks
- Woodland Hills

If you need an *interpreter,* call our Member Service Call Center toll free at **1-800-464-4000**.

If you want to choose a *PCP* from one of *L.A. Care*'s other plan partners, call *L.A. Care* Member Services toll free at **1-888-839-9909**. When the change happens, you must get all of your care from *non–Kaiser Permanente plan providers*.

You may get a new *PCP* if:

- You and your *PCP* cannot get along.
- The *PCP* you chose is not accepting new patients.
- Your *PCP* leaves the *Medical Group* or reduces working hours.
- Your *PCP* stops working at the *Kaiser Permanente plan facility* where you get *services.*

Note: For other reasons why you may get a new *PCP,* please see the "How Your Coverage Can End" section.

Routine Care

Routine care is *medically necessary services* that are not urgent and include preventive services that protect you from disease; promote health; or detect disease early, before symptoms develop.

Some examples are:

- Your new *member* health exam
- Well-child care
- Well-adult care
- Follow-up *services* (such as visits to check on a *chronic* condition)
- Other care that is not *urgent care*

Note: If you need to see your doctor for *routine care*, please see "Appointments and Advice" in the "How to Reach Us" section for the phone number to call. Or you can make an appointment by going online at **kp.org**.

Urgent Care

When you are sick or hurt, you may have an *urgent care* need. This is when you need prompt medical care but do not have an *emergency medical condition*. For *urgent care,* call the advice phone number listed under "Not Sure What Kind of Care You Need?" below.

Appointments

Try to make *routine care* appointments as far ahead as possible. See "Appointments and Advice" in the "How to Reach Us" section for the phone number to call. Or you can make an appointment by going online at **kp.org**.

If you cannot keep an appointment, always call to cancel it.

When You Come in for Care

When you come in for *services*, bring:

- Your *Kaiser Permanente* ID card
- A photo ID
- Your *Medi-Cal* ID card
- A list of health concerns
- Questions that you want answered
- A list of medicines you are taking

Not Sure What Kind of Care You Need?

It can be hard to know what kind of *services* you need. That is why we have licensed health care professionals who can help you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern and instruct you on self-care at home if appropriate.
- They can advise you about whether you should get medical care, and how and where to get care. For example, if you are not sure if your condition is an *emergency medical condition*, they can help you decide if you need *emergency services* or *urgent care*. They can also tell you how and where to get that care.
- They can tell you what to do if you need care and a *Kaiser Permanente plan medical office* is closed.

You can reach one of these licensed health care professionals by calling one of the telephone numbers listed below. When you call, a trained support person may ask you questions to help determine how to direct your call.

To reach a licensed health care professional (24 hours a day, seven days a week), call:

Tri-Central Area

Call toll free, Monday through Friday, 8:30 a.m.–5 p.m., **1-800-780-1277** (TTY **1-800-800-7990**):

- Baldwin Park
- Diamond Bar
- Montebello
- San Dimas
- West Covina

Call toll free, Monday through Friday, 8:30 a.m.–5 p.m., **1-800-780-1230** (TTY **1-800-800-7990**):

- Gardena
- Harbor City
- Long Beach
- Torrance

Call toll free, Monday through Friday, 8:30 a.m.–5 p.m., **1-800-823-4040** (TTY **1-800-800-7990**):

- Bellflower
- Cudahy
- Downey
- Lynwood
- Whittier

Metro Los Angeles Area

Call toll free, Monday through Friday, 7 a.m.–7 p.m.; Saturdays 7 a.m.–noon, **1-800-954-8000** (TTY users, call **711**):

- Culver City
- Glendale
- Inglewood
- Los Angeles (Los Angeles Medical Center, West Los Angeles Medical Center, East Los Angeles Medical Offices, Culver Marina Medical Offices)
- Pasadena

Valleys Area

Call toll free, Monday through Friday, 7 a.m.–7 p.m., **1-888-515-3500** (TTY users call **711**):

- Simi Valley
- Thousand Oaks
- Woodland Hills

Call toll free, Monday through Friday, 7 a.m.–7 p.m., **1-888-778-5000** (TTY users call **711**):

- Lancaster
- Mission Hills
- Palmdale
- Panorama City
- Santa Clarita

After-hours, weekends, and holidays, call **1-888-576-6225** (TTY users call **1-888-880-0833**).

Getting a Referral

Referrals to *Kaiser Permanente Plan* Doctors

A *Kaiser Permanente plan doctor* must refer you before you can get care from most specialists. You must get a *referral* from a *Kaiser Permanente plan doctor* to get care from specialists in:

- Surgery
- Orthopedics
- Cardiology
- Oncology
- Urology
- Dermatology
- Physical, Occupational, and Speech therapies

You do not need a *referral* to get *services* from:

- Your *PCP*
- Generalists in adult medicine, family planning, family practice, and pediatrics
- Specialists in optometry, mental health, chemical dependency, and Ob/Gyn

Medical Group Authorization Process for Some Referrals

Some *services* must be approved ahead of time by the *Medical Group* for the *services* to be covered. *Services* that must be approved:

- ***Durable medical equipment (DME).*** If your *Kaiser Permanente plan doctor* prescribes a *DME* item, he or she will make a written *referral.* If the item is listed on our *DME formulary* for your health problem, it will be *authorized*. Sometimes the item does not look like it meets our *DME formulary* guidelines. In this case, the *Kaiser Permanente plan doctor* is asked for more facts. If the request still does not look like it meets our guidelines, a licensed doctor or other *appropriately qualified medical professional* will review the request. If he or she agrees that the item is *medically necessary,* they will *authorize* it. See "*Durable Medical Equipment*" in the "Benefits" section to learn more about our *DME formulary.*
- ***Ostomy supplies* and *urological supplies.*** If you need *ostomy* or *urological supplies,* your *Kaiser Permanente plan doctor* will make a written *referral* for the item(s). If the item(s) is listed on our soft goods *formulary* for your health problem, it will be *authorized.* Sometimes the item(s) does not appear to meet our soft goods *formulary* guidelines. In these cases, the *Kaiser Permanente plan doctor* is asked for more facts. If the request still does not look like it meets our guidelines, a licensed doctor or other *appropriately qualified medical professional* will review the request. If he or she agrees that the item(s) is *medically necessary,* they will *authorize* the item(s). See "*Ostomy Supplies* and *Urological Supplies*" in the "Benefits" section for more about our soft goods *formulary.*
- **Services you cannot get from *Kaiser Permanente plan providers* in the *Kaiser Permanente Service Area*.** Sometimes you may need *services* that you cannot get from a *Kaiser Permanente plan provider.* If your *Kaiser Permanente plan doctor* thinks you need covered *services* that you cannot get from a *Kaiser Permanente plan provider*, he or she will request the *Medical Group* to refer you to a *non–Kaiser Permanente plan provider*. Either a licensed doctor or other *appropriately qualified medical professional* reviews the request. If he or she agrees that the *services* are *medically necessary,* they will *authorize* the *services.* When you are referred to a *non–Kaiser Permanente plan doctor,* it will be for a specific treatment plan. In cases where the care ordered is ongoing, a standing *referral* is issued. Be sure to ask your *Kaiser Permanente plan doctor* what *services* have been *authorized.*
- **Transplants.** If you need a transplant that we cover, your *Kaiser Permanente plan doctor* will make a written *referral.* The *Medical Group*'s regional transplant

board (if one exists) will *authorize* the *services* if they agree that the *services* are *medically necessary*. If no transplant board exists, the *Medical Group* will refer you to a doctor at a transplant center. If he or she agrees that the *services* are *medically necessary,* they will *authorize* the *services*. See "Transplant Services" in the "Benefits" section to learn about coverage of transplants. Note**:** Corneal transplants by a *Kaiser Permanente plan doctor* do not need to be *authorized.*

Decisions on requests for *services* will be made only by licensed doctors or other *appropriately qualified medical professionals*.

Covered referral *services* are provided at **no charge.**

Medical Group **decision time frames.** Before the *Medical Group* can make a decision, they must have all the facts. Facts include exam and test results. Decisions are made by either a licensed doctor or other *appropriately qualified medical professional.* For *services* that are not urgent, decisions are made within five days. If *services* are urgent, decisions are made no later than 72 hours.

Sometimes more time is needed. This can happen if the *Medical Group* does not have all the facts or tests they need, or has asked for a consult by a doctor who is an expert in the care you have asked for. If the *Medical Group* cannot meet these time frames, they will let you and the doctor who is treating you know in writing. The *Medical Group* will let you know the facts or tests they need or the type of expert they need to consult. The *Medical Group* will also let you know the date they think your request will be decided.

The doctor who is treating you will be told of the decision within 24 hours after it is made. If the *services* are *authorized*, your doctor will be told what *services* were *authorized.* If the *Medical Group* does not *authorize* all of the *services*, we will send you a letter that tells you about the decision. You will get this letter within two business days after the decision is made. The letter will tell you other ways to solve the problem. You can ask for the standards that the *Medical Group* used to decide to *authorize*, change, delay, or deny your request for *services.*

This is only a short review of the *authorization* process. To learn more, call our Member Service Call Center. You can get a copy of our policies and procedures, which include the *authorization* process that applies to some *Kaiser Permanente plan providers*, other than Kaiser Foundation Hospitals and the *Medical Group*. See "Post-Stabilization Care" in the "Emergency Services and Urgent Care" section for the *authorization* process for *post-stabilization care.*

Second Opinions

If you ask for a second opinion, you will get one when *medically necessary* from an *appropriately qualified medical professional* at **no charge.** Some examples of when a second opinion is *medically necessary* are:

- You have questions about the treatment your *Kaiser Permanente plan doctor* suggests.
- You have questions about a health issue or care plan for a condition that can cause a lot of damage or loss of life, limb, or body functions.
- The symptoms are not clear or are hard to understand.
- A diagnosis given does not match the test results.
- The *Kaiser Permanente plan doctor* cannot figure out what is wrong with you.
- Treatment is not making you better.
- You are concerned about a health issue or care plan.

To get a second opinion, you can ask your *Kaiser Permanente plan doctor* to help you get a second opinion. You can also make an appointment with a different *Kaiser Permanente plan doctor* in the *Kaiser Permanente service area.*

If the *Medical Group* finds that there is no *Kaiser Permanente plan doctor* in the *Kaiser Permanente service area* who is an *appropriately qualified medical professional* for your condition, the *Medical Group* will *authorize* a *referral* to a *non–Kaiser Permanente plan doctor* for a *medically necessary* second opinion.

Call our Member Service Call Center to learn more.

Contracts with *Kaiser Permanente Plan* Providers

How *Kaiser Permanente Plan* Providers Are Paid

Kaiser Foundation Health Plan, Inc., contracts with *Kaiser Permanente plan providers* to provide *services* to *members*. *Kaiser Permanente plan providers* are paid in a number of ways. Some of the ways *Kaiser Permanente plan providers* are paid are by salary, a fixed payment for each *member*, a payment for each day that someone gets *services*, a payment for each case, a payment based on the *services* someone receives, or incentive payments. To learn more about how *Kaiser Permanente plan providers* are paid, ask your *Kaiser Permanente plan doctor* or call our Member Service Call Center.

Financial Liability

Our contracts with *Kaiser Permanente plan providers* say that you will not have to pay any money that we owe. But if you get *services* that are not covered by *Medi-Cal,* you may have to pay for the cost of *services.*

If a *Kaiser Permanente Plan* Provider's Contract Ends

If our contract with any *Kaiser Permanente plan provider* ends while you are getting *services* from them, we will pay for the *services* until we arrange for you to get *services* from a *Kaiser Permanente plan provider.* We will let you know when our coverage for *services* from that provider ends.

Provider groups and hospitals. If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Completion of services from *non–Kaiser Permanente plan providers*. If you are getting covered *services* from a *Kaiser Permanente plan hospital* or a *Kaiser Permanente plan doctor* (or certain other providers) when our contract with the provider ends (except if the contract ended for cause), you may be able to keep getting some *services* at **no charge** from that provider for:

- ***Acute* conditions.** We may cover these *services* until the *acute* condition ends.
- **Serious *chronic* conditions.** We may cover *services* until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the first day after a course of treatment is complete when it would be safe to transfer your care to a *Kaiser Permanente plan provider*, as determined by *Kaiser Permanente* after talking with the *member* and *non–Kaiser Permanente plan provider* and consistent with good professional practice. Serious *chronic* conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure.
  - it gets worse over a long period of time.
  - it requires ongoing treatment to maintain remission or prevent the condition from getting worse.
- **Maternity care.** We may cover these *services* while you are pregnant and right after you give birth.
- **Terminal illnesses.** We may cover these *services* for the duration of the illness. Terminal illnesses are illnesses that cannot be cured or reversed and are likely to cause death within a year or less.
- **Care for children under age 3.** We may cover these *services* until the earlier of (1) 12 months from the date the provider's contract ended; or (2) the child's third birthday.
- **Surgery or another procedure that is part of a course of treatment.** The care must be recommended and documented by the provider to occur

within 180 days of the date the provider's contract ended.

To get this coverage, all of the following must be true:

- Your *Kaiser Permanente* coverage is in effect on the date you receive the *service.*
- You are getting *services* from a provider whose contract has ended on the provider's termination date.
- The provider agrees in writing to our contract terms and conditions (for example, conditions pertaining to payment and to providing *services* inside the *Kaiser Permanente service area*).
- The *services* are *medically necessary* and would be covered *services* under this *Member Handbook* if you got them from a *Kaiser Permanente plan provider.*
- You request the *services* within 30 days (or as soon as you can) from the date the provider's contract ended.

To learn more and to request *services* or a copy of our "Completion of Services" policy, call our Member Service Call Center.

Health Exam for New *Members*

If you or your child is a new *member,* make an appointment as soon as you can with your *PCP* (*Primary Care Provider*):

- Children younger than 18 months should have an exam within two months (60 days) of joining.
- Adults and children age 18 months or older should have an exam within four months (120 days) of joining.

This exam is important. Your *PCP* can take better care of you by knowing your health history. Even if you feel well, your *PCP* may find a health problem.

If you have recently been a *member*, you might not need this exam. To find out, talk to your *PCP*.

Care for Teens

If you are age 12 or older, your parent does not have to give approval for you to get:

- *Services* related to sexual assault (including rape)
- *Chemical dependency services*
- Pregnancy *services*
- *Family planning services* (see "*Family Planning Services*" in the "Benefits" section)
- *Sensitive services* (see "STD Services" in the "*Sensitive Services*" section)

If you are age 12 or older, your parent may not have to give approval for you to get:

- Outpatient *specialty mental health services*

To learn when the law requires your parent's approval, talk to your *Kaiser Permanente plan doctor*.

See the "Benefits" and "*Exclusions*, *Limitations*, and *Reductions*" sections on how to get these *services*.

If You Are Pregnant

If you think you are pregnant, get a pregnancy test right away. Call the Ob/Gyn Department to find out how to get this test. See "Appointments and advice" in the "How to Reach Us" section for the Ob/Gyn Department phone number.

Prenatal Care

Prenatal care is care you receive while you are pregnant. Once you know you are pregnant, call the Ob/Gyn Department to make an appointment for prenatal care and a *health education* assessment. This care is important for you and your baby. The Ob/Gyn Department can also help you choose an Ob/Gyn doctor who is taking new patients. You can also ask for a *certified nurse midwife*. If you ask for a *certified nurse midwife* and you cannot get these *services* from a *Kaiser Permanente plan provider,* the Ob/Gyn Department will suggest that you be referred to a *non–Kaiser Permanente plan provider*. To learn more about *referrals* to *non–Kaiser Permanente plan providers*, please see the "Getting a Referral" section.

Hospital Inpatient Care

After you have your baby, your *Kaiser Permanente plan provider* will talk with you about how long you need to be in the hospital. How long you stay in the hospital will be based on what is needed for your recovery.

Follow-up Visits

After you go home from the hospital, your *Kaiser Permanente plan provider* may order a follow-up visit. This may happen if you go home sooner than 48 hours after a normal delivery or 96 hours after a C-section. This visit might be at a *Kaiser Permanente plan facility* or at your home. Your *Kaiser Permanente plan provider* will let you know where this visit will be.

Health Education

Our *health education* programs can help you learn how to protect and improve your health.

Ask Your PCP *(Primary Care Provider)*

Your *PCP* can give you advice and *health education* materials.

Website

You can get *health education* information by going online at **kp.org**.

Health Education Centers

Our *Health Education* Centers have videos, materials to read, and brochures to take home.

Health Education Programs

If you have a *chronic* condition like asthma, diabetes, or heart disease, we offer *health education* programs that can help you live better. We also cover programs to help you stop smoking and manage stress. To learn more, call our Member Service Call Center.

Using the Pharmacy

New Prescriptions

You must get your prescriptions filled at a *Kaiser Permanente plan pharmacy* or through our mail-order service unless the item is covered *emergency services*, *post-stabilization care*, or *out-of-area urgent care*.

Refills

When you need a refill, you may phone ahead, order by mail, or order online.

A few pharmacies do not dispense covered refills, and not all drugs can be mailed through our mail-order service. Check with your local *Kaiser Permanente plan pharmacy* or *Your Guidebook* if you have a question about whether or not your prescribed drug can be mailed or obtained at a *Kaiser Permanente plan pharmacy*. Items available through our mail-order service are subject to change at any time without notice.

See *Your Guidebook* for locations and hours of *Kaiser Permanente plan pharmacies* in your area. To find out if a drug is on our drug *formulary*, please call our Member Service Call Center.

Pickup and Mail Order

You can phone in your refill to a *Kaiser Permanente plan pharmacy*. The phone number to call is on your prescription label. You can pick up your refill at the *Kaiser Permanente plan pharmacy* or you can ask for delivery by mail. Allow one week for delivery by mail after you call in your order. If you have used all of your refills, the pharmacy will contact your *Kaiser Permanente plan doctor* to get an approval for more refills.

Order Online

You can order your refill by going online at **kp.org**. You can then pick up your refill at the *Kaiser Permanente plan pharmacy* or you can ask for delivery by mail.

Medicare Part D

If you are covered by *Medi-Cal* and eligible for or enrolled in *Medicare* with Part D coverage, Medicare Part D pays first. Sometimes a drug covered by *Medi-Cal* may not be covered by Medicare Part D. If *Medicare* does not cover a drug that was covered by *Medi-Cal,* it may still be covered under your *Medi-Cal* coverage. If you are a *Kaiser Permanente* Senior Advantage *member* and want to know more about your Medicare Part D drug coverage, see your Senior Advantage *Evidence of Coverage.* You

can also learn how to get extra help to pay for your out-of-pocket expenses.

To learn more about Medicare Part D (including how to enroll in Part D), please call our Member Service Call Center toll free at **1-800-443-0815** (**TTY** users call **1-800-777-1370**). You can also call Medicare toll free at **1-800-MEDICARE** (**1-800-633-4227**) (**TTY** users call **1-877-486-2048)** or visit their website at **www.medicare.gov**.

Your ID Cards

You will get a *Kaiser Permanente* ID card from us and a *Medi-Cal* ID card from the *California Department of Health Care Services*. Bring both of these cards and a photo ID with you when you come in to get *services*.

Your *Kaiser Permanente* ID Card

Your *Kaiser Permanente* ID card has your name and medical record number on it. We use this number to track your records. You should always have the same medical record number. If we give you a new medical record number by mistake, or if you need to replace your ID card, call our Member Service Call Center.

Your *Medi-Cal* ID Card

Your *Medi-Cal* ID card has your *Medi-Cal* number on it. We use this card to check if you have *Medi-Cal* coverage. You will also need this card to get *services* that we do not cover. See "Exclusions" in the "*Exclusions*, *Limitations*, and *Reductions*" section for *services* that you must get through *regular Medi-Cal* or other programs.

Using Your ID Cards Properly

To get *services*, you must be a current *member*. We will bill anyone who is not a *member* for *services* he or she gets. Do not let anyone use your ID cards. You could lose *Medi-Cal* coverage if you do.

Kaiser Permanente Plan Facilities

At most of our *Kaiser Permanente plan facilities*, you can usually get all of the covered *services* you need. Covered *services* include specialty care, *pharmacy services*, and lab tests.

All *Kaiser Permanente plan hospitals* and most *Kaiser Permanente plan medical offices* in the *Kaiser Permanente service area* are listed in this section:

- All *Kaiser Permanente plan hospitals* provide inpatient *services* and are open 24 hours a day, seven days a week.
- *Emergency services* are available at *Kaiser Permanente plan hospital* Emergency Departments.
- Same-day *urgent care* appointments are available at many locations (look in *Your Guidebook* for *urgent care* locations in your area).
- Many *Kaiser Permanente plan medical offices* have evening and weekend appointments.
- Many *Kaiser Permanente plan facilities* have Member Services offices. See the "How to Get Help" section for locations of Member Services offices in your area.

Kaiser Permanente Plan Hospitals and Plan *Medical Offices*

This section includes a list of *Kaiser Permanente plan hospitals* and most *Kaiser Permanente plan medical offices* in the *Kaiser Permanente service area*. See *Your Guidebook* or look online at **kp.org** for a complete list of *Kaiser Permanente plan medical offices*. Also, please read *Your Guidebook* to learn about the types of covered *services* you can get at each *Kaiser Permanente plan facility* in your area. Some *Kaiser Permanente plan facilities* provide only specific types of covered *services*. The list of *Kaiser Permanente plan hospitals* and *Kaiser Permanente plan medical offices* in this *Member Handbook* is up-to-date as of July 1, 2012. If you have any questions about the current locations of *Kaiser Permanente plan facilities*, call our Member Service Call Center.

Aliso Viejo

- Medical Offices: 24502 Pacific Park Dr.

Anaheim

- Hospital and Medical Offices: 441 N. Lakeview Ave.
- Medical Offices: 411 N. Lakeview Ave., 5475 E La Palma Ave. and 1188 N. Euclid St.

Bakersfield

- Hospital: 2615 Chester Ave. (San Joaquin Community Hospital
- Medical Offices: 1200 Discovery Dr., 3501 Stockdale Hwy., 3700 Mall View Rd., 4801 Coffee Rd., and 8800 Ming Ave.

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Medical offices: 9400 E. Rosecrans Ave.

Bonita

- Medical offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert Rd.

Carlsbad

- Medical Offices: 6860 Avenida Encinas

Chino

- Medical Offices: 11911 Central Ave.

Claremont

- Medical Offices: 250 W. San Jose St.

Colton

- Medical Offices: 789 S. Cooley Dr.

Corona

- Medical Offices: 2055 Kellogg Ave.

Cudahy

- Medical Offices: 7825 Atlantic Ave.

Culver City

- Medical Offices: 5620 Mesmer Ave.

Diamond Bar

- Medical Offices: 1336 Bridge Gate Dr.

Downey

- Hospital: 9333 E. Imperial Hwy.
- Medical Offices: 9449 E. Imperial Hwy.

El Cajon

- Medical Offices: 1630 E. Main St.

Escondido

- Hospital: 555 E. Valley Pkwy. (Palomar Medical Center)
- Medical Offices: 732 N. Broadway St.

Fontana

- Hospital and Medical Offices: 9961 Sierra Ave.

Garden Grove

- Medical Offices: 12100 Euclid St.

Gardena

- Medical Offices: 15446 S. Western Ave.

Glendale

- Medical Offices: 444 W. Glenoaks Blvd.

Harbor City

- Hospital and Medical Offices: 25825 S. Vermont Ave.

Huntington Beach

- Medical Offices: 18081 Beach Blvd.

Inglewood

- Medical Offices: 110 N. La Brea Ave.

Irvine

- Hospital and Medical Offices: 6640 Alton Pkwy.
- Medical Offices: 6 Willard St.

La Mesa

- Medical Offices: 8080 Parkway Dr. and 3875 Avocado Blvd.

La Palma

- Medical Offices: 5 Centerpointe Dr.

Lancaster

- Hospital: 1600 W. Avenue J (Antelope Valley Hospital)
- Medical Offices: 43112 N. 15th St. W.

Long Beach

- Medical Offices: 3900 E. Pacific Coast Hwy.

Los Angeles

- Hospitals and Medical Offices: 1526 N. Edgemont St. and 6041 Cadillac Ave.
- Medical Offices: 5119 E. Pomona Blvd. and 12001 W. Washington Blvd.

Lynwood

- Medical Offices: 3840 Martin Luther King Jr. Blvd.

Mission Hills

- Medical Offices: 11001 Sepulveda Blvd.

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

- Hospital: 27300 Iris Ave. (Moreno Valley Community Hospital)
- Medical Offices: 12815 Heacock St.

Murrieta

- Hospital: 25500 Medical Center Dr. (Rancho Springs Medical Center)

Oceanside

- Medical Offices: 3609 Ocean Ranch Blvd.

Ontario

- Medical Offices: 2295 S. Vineyard Ave.

Oxnard

- Medical Offices: 2200 E. Gonzales Rd.

Palmdale

- Medical Offices: 4502 E. Avenue S

Panorama City

- Hospital and Medical Offices: 13652 Cantara St.

Pasadena

- Medical Offices: 3280 E. Foothill Blvd.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Redlands

- Medical Offices: 1301 California St.

Riverside

- Hospital and Medical Offices: 10800 Magnolia Ave.

San Bernardino

- Medical Offices: 1717 Date Pl.

San Diego

- Hospital and Medical Offices: 4647 Zion Ave.
- Medical Offices: 3250 Wing St., 4405 Vandever Ave., 4650 Palm Ave., 7060 Clairemont Mesa Blvd., and 11939 Rancho Bernardo Rd.

San Dimas

- Medical Offices: 1255 W. Arrow Hwy.

San Juan Capistrano

- Medical Offices: 30400 Camino Capistrano

San Marcos

- Medical Offices: 400 Craven Rd.

Santa Ana

- Medical Offices: 3401 S. Harbor Blvd. and 1900 E. 4th St.

Santa Clarita

- Medical Offices: 27107 Tourney Rd.

Simi Valley

- Medical Offices: 3900 Alamo St.

Temecula

- Medical Offices: 27309 Madison Ave.

Thousand Oaks

- Medical Offices: 365 E. Hillcrest Dr. and 145 Hodencamp Rd.

Torrance

- Medical Offices: 20790 Madrona Ave.

Upland

- Medical Offices: 1183 E. Foothill Blvd.

Victorville

- Medical Offices: 14011 Park Ave.

West Covina

- Medical Offices: 1249 Sunset Ave.

Whittier

- Medical Offices: 12470 Whittier Blvd.

Wildomar

- Hospital: 36485 Inland Valley Dr. (Inland Valley Medical Center)
- Medical Offices: 36450 Inland Valley Dr.

Woodland Hills

- Hospital and Medical Offices: 5601 De Soto Ave.
- Medical Offices: 21263 Erwin St.

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

Affiliated *Kaiser* Permanente Plan Hospitals in Western Ventura County

Ventura
Community Memorial Hospital
of San Buenaventura
(*emergency services* only)
147 N. Brent St.

Affiliated *Kaiser Permanente* Plan Hospitals in Coachella Valley

Palm Springs
Desert Regional Medical Center
(*emergency services* only)
1150 N. Indian Canyon Dr.

Joshua Tree
Hi-Desert Medical Center
(*emergency services* only)
6601 White Feather Rd.

Indio
John F. Kennedy Memorial Hospital
(*emergency services* only)
47111 Monroe St.

Note: State law requires this *Member Handbook* to include the following notice: "Some hospitals and other providers do not provide one or more of the following *services* that may be covered under your plan contract and that you or your family member may need: *family planning services;* birth control drugs and items, including emergency contraception, surgical birth control, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion.

"You should get more facts before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the *Kaiser Permanente* Member Service Call Center, to

make sure that you can get the *services* that you need."

If a *service* is covered but is not available at one of our *Kaiser Permanente plan facilities*, you will be able to get the *service* at a different *Kaiser Permanente plan facility*.

Your Guidebook to *Kaiser Permanente Services*

Kaiser Permanente plan medical offices and *Kaiser Permanente plan hospitals* for your area are listed in more detail in *Your Guidebook to Kaiser Permanente Services* (*Your Guidebook*). Some facilities provide only certain types of covered *services*. *Your Guidebook* tells you the types of covered *services* that you can get from each *Kaiser Permanente plan facility*. It includes facilities that are not listed in this "Kaiser Permanente Plan Facilities" section. Also, it tells you how to use our *services,* how to make appointments, and when we are open. It also includes a detailed phone listing for appointments and advice. *Your Guidebook* has other important information, such as how to stay healthy.

Your Guidebook is subject to change and is updated from time to time. You can get a copy by calling our Member Service Call Center or by going online at **kp.org**.

Emergency Services and Urgent Care

Emergency Services

If you have an *emergency medical condition,* call **911** or go to the nearest hospital. You do not need to get an approval from us to get *emergency services*. We cover *emergency services* from *Kaiser Permanente plan providers* and *non–Kaiser Permanente plan providers* anywhere in the world, as long as the *services* would have been covered under the "Benefits" section (subject to any exclusions, limitations, or reductions) if you received them from a *Kaiser Permanente plan provider*.

Emergency services are available from *Kaiser Permanente plan hospital* Emergency Departments 24 hours a day, seven days a week.

Go to your *Kaiser Permanente plan doctor* for follow-up care after you leave the hospital. Do not go back to the emergency room for follow-up care.

Post-Stabilization Care

Post-stabilization care is the *medically necessary services* that you get after the doctor who is treating you finds that your *emergency medical condition* is *stabilized*. We cover *post-stabilization care* from a *non–Kaiser Permanente plan provider*, including inpatient care at a *non–Kaiser Permanente plan hospital*, only if we provide prior *authorization* or if otherwise required by applicable law. Prior *authorization* means that we must approve the *services* before you get the *services*. **The *non-Kaiser Permanente plan provider* treating you must get *authorization* from us before we will pay for *post-stabilization care*.**

To get prior *authorization* to receive *post-stabilization care* from a *non–Kaiser Permanente plan provider,* the *non–Kaiser Permanente plan provider* must call us toll free at **1-800-225-8883** (**TTY** users, call **711**). They can also call the phone number on the back of your *Kaiser Permanente* ID card. The *non–Kaiser Permanente plan provider* must call us before you get the *services*. If they are not able to call before you get the *services*, then they must call us as soon as possible.

When the *non–Kaiser Permanente plan provider* calls, we will talk to the doctor who is treating you about your health issue. If we decide you need *post-stabilization care,* we will *authorize* the *services*. In some cases, we may arrange to have a *Kaiser Permanente plan provider* provide the *services.*

If we decide to have a *Kaiser Permanente plan hospital, Kaiser Permanente plan skilled nursing facility,* or a *non–Kaiser Permanente plan provider* provide the care, we may *authorize* transport *services* that are medically needed to get you to the provider. This may include special

transport *services* that we would not normally cover.

You should ask the *non–Kaiser Permanente plan provider* what care (including any transport) we have *authorized*. We cover only the *services* or related transport that we *authorized*. If you ask for and get *services* that are not covered, we may not pay the *non–Kaiser Permanente plan provider* for the *services*.

Urgent Care

Inside the Service Area

An *urgent care* need is one that requires prompt medical attention but is not an *emergency medical condition*. If you think you may need *urgent care*, call the appropriate appointment or advice telephone number at a *Kaiser Permanente plan facility*. Please look in *Your Guidebook* for appointment and advice telephone numbers.

Out-of-Area Urgent Care

You do not need to get an approval from us before you get *out-of-area urgent care*. *Urgent care* is something that needs to be taken care of promptly but is not an *emergency medical condition*. We cover *medically necessary services* from a *non–Kaiser Permanente plan provider* to keep your health (or your unborn child's health) from seriously worsening if:

- You did not know ahead of time that you needed the care.
- You receive the *services* from *non–Kaiser Permanente plan providers* while you are temporarily outside of the *Kaiser Permanente service area.*
- You reasonably believed that your (or your unborn child's) health would seriously worsen if care was delayed until you returned to the *Kaiser Permanente service area.*

We cover *out-of-area urgent care* you receive from *non-plan providers* as long as the *services* would have been covered under the "Benefits" section (subject to the "*Exclusions*, *Limitations*, and *Reductions*" section) if you had received them from *Kaiser Permanente plan providers*.

Related *Services*

This section tells you only about coverage for *emergency service* and *urgent care services* from *non–Kaiser Permanente plan providers*.

Please see the "Benefits" section to learn about coverage for:

- Follow-up care that is related to your *emergency medical condition* (for example, coverage for outpatient drugs prescribed by a *non–Kaiser Permanente plan provider* that are related to your *emergency medical condition*)
- Coverage of *emergency services*, *post-stabilization care*, and *urgent care* from *Kaiser Permanente plan providers*

If You Get a Bill

If you get a bill or had to pay for *services* from a *non–Kaiser Permanente plan provider* for covered *emergency services*, *post-stabilization care*, or *out-of-area urgent care*, you must file a claim. Also, in some cases you may have to pay for *services* ordered by a *non–Kaiser Permanente plan provider* as part of covered *emergency services*, *post-stabilization care*, or *out-of-area urgent care;* for example, drugs ordered by the *non–Kaiser Permanente plan provider*.

How to File a Claim

To file a claim for payment or get money back, this is what you need to do:

- As soon as you can, send us a completed claim form. You can get a claim form online at **kp.org.** You can also call our Member Service Call Center toll free at **1-800-464-4000** or **1-800-390-3510** (**TTY** users call **1-800-777-1370**). We will be happy to help you if you need help completing our claim form.
- If you have paid for *services*, you must include any bills and receipts from the *non–Kaiser Permanente plan provider* with your claim form.
- If you want us to pay the *non–Kaiser Permanente plan provider* for *services*, you must include any bills from the *non–Kaiser Permanente plan provider* with your claim form. If you later get any bills from the *non–Kaiser Permanente plan provider*, please call our Member Service Call Center toll free at **1-800-390-3510** (**TTY** users call **1-800-777-1370**)for help.
- You must send us the completed claim form as soon as you can after getting the care.
- The completed claim form and any bills or receipts must be mailed to:

  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

If we need more facts from you or the *non–Kaiser Permanente plan provider*, we may follow up with you or the *non–Kaiser Permanente plan provider*. The information we ask for must be sent to our Claims Department at the address above. For example, we might ask you or the *non–Kaiser Permanente plan provider* to fill out a claim form, have you sign forms for the release of medical records, or provide proof of your travel.

If you asked us to pay you back for *services* that you paid for and we do not approve the request, we will let you know in writing within 30 days after we receive your claim. We will tell you why we did not approve your request and other ways to solve the problem. To learn more about other ways to solve problems, go to the "How to Solve Problems" section of this *Member Handbook*.

Benefits

This section tells you about *services* that we cover. You can get covered *services* only if you are a *member* on the date that you get the *services* and the *services* are *medically necessary*. Most *services* listed in this section are covered only if:

- A *Kaiser Permanente plan doctor* provides, prescribes, directs, or *authorizes* the *services*;
- You get the *services* from *Kaiser Permanente plan providers* in the *Kaiser Permanente service area;* and
- The *Medical Group* has *authorized* the *services* if the *services* require *Medical Group authorization* (See "*Medical Group Authorization* Process for Some *Referrals*" in the "How to Get Care" section to find out what *services* need *Medical Group authorization*).

This section also tells you about *exclusions* that apply to each benefit. See the "*Exclusions*, *Limitations*, and *Reductions*" section for *exclusions* that apply to all benefits. Also, see *Your Guidebook* for the types of covered *services* that are available from each *Kaiser Permanente plan facility*; some facilities provide only specific types of covered *services*. If you need a covered *service* but you cannot get it at one of our *Kaiser Permanente plan facilities*, you will be able to get the *service* at a different *Kaiser Permanente plan facility*.

Copays

Covered *services* are provided at **no charge.** If you ask for and get *services* that are not covered, you may have to pay for these *services*.

Hospital Inpatient Care

Hospital inpatient care is *services* that you get when you are admitted to a *Kaiser Permanente plan hospital*.

We cover the following *services* at **no charge:**

- A room you share with one or more people, unless a private room is *medically necessary.*
- Meals.
- Special care units.
- Nursing *services.*
- Operating room and related *services.*
- *Services* of *Kaiser Permanente plan doctors.*
- Anesthesia.
- Drugs prescribed in accord with our drug *formulary* guidelines.
- Radioactive materials used for treatment.
- *Durable medical equipment* and medical supplies.
- Imaging, lab tests, and special procedures.
- Blood and blood products.
- Labor and delivery. Your *Kaiser Permanente plan doctor* may order

follow-up visits if you go home from the hospital sooner than 48 hours after a normal delivery or 96 hours after a C-section.

- *Physical therapy*, *occupational therapy*, and *speech therapy* (including care in an organized, multidisciplinary rehabilitation program).
- *Respiratory therapy.*
- Medical social services and planning for care after you leave the hospital.

The following *services* are covered only as listed in these headings in this "Benefits" section:

- *Chemical Dependency Services*
- Dental *Services* for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Medical Transportation
- *Ostomy Supplies* and *Urological Supplies*
- *Prosthetic Devices* and *Orthotic Devices*
- *Reconstructive Surgery*
- *Services* Related to *Clinical Trials*
- Skilled Nursing/Intermediate/ Subacute Facility Care
- Transplant *Services*

Outpatient Care

Outpatient care is *services* that you get in a *Kaiser Permanente plan medical office* or in a *Kaiser Permanente plan hospital* when you have not been admitted to the hospital.

We cover the following *services* at **no charge:**

- Primary care and specialty care consultations and exams
- Hearing tests to find out if you need a hearing aid
- Vision exams to find out if you need eyeglasses and to provide a prescription for eyeglasses
- Outpatient surgery
- *Physical therapy*, *occupational therapy*, and *speech therapy* (including care in an organized, multidisciplinary rehabilitation day treatment program)
- Emergency Department visits
- House calls by a *Kaiser Permanente plan doctor* (or a *Kaiser Permanente plan provider* who is a registered nurse) in the *Kaiser Permanente service area* when your *Kaiser Permanente plan doctor* finds that you can best get *services* in your home
- Blood and blood products

The following *services* are covered only as listed in these headings in this "Benefits" section:

- Dental *Services* for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- *Durable Medical Equipment*
- *Family Planning Services*

- *Health Education*
- Hearing *Services*
- Home Health Care
- Hospice Care
- Medical Transportation
- Mental Health *Services*
- *Ostomy Supplies* and *Urological Supplies*
- Outpatient Imaging, Lab Tests, and Special Procedures
- Outpatient *Pharmacy Services*
- *Prosthetic Devices* and *Orthotic Devices*
- *Reconstructive Surgery*
- *Sensitive Services*
- *Services* Related to *Clinical Trials*
- Transplant *Services*
- Vision *Services*

Chemical Dependency Services

Chemical dependency services are *services* for alcohol or drug abuse.

Inpatient Care

We cover *services* at **no charge** in a *Kaiser Permanente plan hospital* only for *medically necessary* management of withdrawal symptoms.

Exclusions

We do not cover any other *chemical dependency services*. You must get these *services* from the Los Angeles County Mental Health Department. Call toll free **1-800-854-7771** to learn more.

If you are age 12 or older, your parent does not have to give approval for you to get these *services*. To learn when the law requires your parent's approval, talk to your *Kaiser Permanente plan doctor.*

Dental *Services* for Radiation Treatment and Dental Anesthesia

Dental *Services* for Radiation Treatment

We cover *services* to prepare your jaw for radiation treatment for cancer in your jaw or neck at **no charge.** These *services* include dental exams, X-rays, fluoride treatment, or having any teeth pulled. You must get these *services* from a *Kaiser Permanente plan doctor* or, if the *Medical Group authorizes* a *referral,* from a dentist.

Dental Anesthesia

For dental procedures at a *Kaiser Permanente plan facility*, we provide general anesthesia and facility *services* related to the anesthesia at **no charge** if:

- You are under age 7, or you are developmentally disabled, or your health is compromised; and
- Your clinical status or underlying medical condition requires that you get

the dental procedure in a hospital or outpatient surgery center; and

- The dental procedure would not usually require general anesthesia.

We do not cover any other *services* related to the dental care, such as the dentist's *services*.

Dialysis Care

We cover *acute* and *chronic* dialysis *services* at **no charge** if:

- You get the *services* in the *Kaiser Permanente service area*.
- You meet all medical criteria developed by the *Medical Group* and by the facility providing the dialysis.
- We provide a *referral* for care.

After you get training at a dialysis facility we choose, we also cover equipment and medical supplies needed for home hemodialysis and home peritoneal dialysis inside the *Kaiser Permanente service area* at **no charge**. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or buy the equipment and supplies, and whom we will rent or buy it from. You must return the equipment and any unused supplies to us when we are no longer covering them.

Exclusions

We do not cover:

- Comfort, convenience, or luxury equipment, supplies, and features.
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel.

Durable Medical Equipment

Durable medical equipment (DME) is something that:

- Can withstand repeated use
- Is used for a medical purpose
- Is generally not useful to someone who is not ill or hurt
- Is safe for use in or out of the home

Inside the *Kaiser Permanente service area*, we cover *DME* items in accord with our *DME formulary* and *Medi-Cal* guidelines. Coverage is limited to the lowest-cost *DME* that meets your medical needs. We decide whether to rent or buy the *DME*, and whom we will rent or buy it from. We will fix or replace the *DME* unless you lose or misuse it. You must give the *DME* back to us when we are no longer covering it.

DME Items for Diabetes

The following diabetes blood testing supplies and equipment and insulin-administration devices are covered under this "*Durable Medical Equipment*" section:

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

Outside the *Kaiser Permanente Service Area*

We do not cover most *DME* for home use outside the *Kaiser Permanente service area*. However, if you live outside the *Kaiser Permanente service area*, we cover the following *DME* items (subject to all coverage requirements that apply to *DME* for home use inside the *Kaiser Permanente service area*) when the item is dispensed at a *Kaiser Permanente plan facility*:

- Standard curved handle cane
- Standard crutches
- For diabetes blood testing, blood glucose monitors and their suppliessuch as blood glucose monitor test strips, lancets, and lancet devices) from a *Kaiser Permanente plan pharmacy*
- Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a *Kaiser Permanente plan pharmacy*

Our *DME Formulary*

Our *DME formulary* is a list of *DME* that has been approved by our *DME* Executive Review Committee for our *members.* The list was developed by a work group with input from *Kaiser Permanente plan doctors* and medical professionals who have expertise in *DME* (like physical therapists and home health nurses). The committee reviews and revises the list from time to time to keep up with changes in medical technology and clinical practice.

To find out if an item is on the list, call our Member Service Call Center. Our *DME formulary* guidelines allow you to get items that are not on the list if they are otherwise covered and the *Medical Group* finds that the item is *medically necessary*.

Exclusions

We do not cover:

- Luxury items
- Dental appliances
- Items used for exercise
- Items used for hygiene (unless *Medi-Cal* criteria have been met)
- Household or furniture items
- Changes to your home or car
- Items that test blood or other fluids (except blood glucose monitors and their supplies, such as blood glucose monitor test strips, lancets, and lancet devices)

- Items that monitor the heart or lungs (except infant apnea monitors)
- More than one item of *DME* that does the same thing

Family Planning Services

Family planning services are *medically necessary services* that prevent or delay pregnancy.

We cover visits at **no charge** for:

- Counseling on birth control options
- Contraceptive drugs and items, including *emergency contraceptives* (as described under "Outpatient *Pharmacy Services*" in this "Benefits" section), when prescribed in accord with our drug formulary guidelines
- Surgical birth control
- Pregnancy tests and counseling
- Care for medical problems related to birth control methods

If you are age 12 or older, your parent does not have to give approval for you to get *family planning services*. To learn when the law requires parental approval, talk to your *Kaiser Permanente plan doctor.*

You can get *family planning services* from a *Kaiser Permanente plan provider*. You can also get *family planning services* from a *non–Kaiser Permanente plan provider* that accepts *Medi-Cal*. Your *PCP* does not have to *authorize* these *services*. We will pay the *non–Kaiser Permanente plan provider* for the covered *services* that you get. Call the California Office of Family Planning toll free at **1-800-942-1054** if you want help in finding a provider.

Health Education

Our *health education* programs can help you learn how to protect and improve your health. We cover programs that help you:

- Stop smoking or chewing tobacco
- Manage stress
- Live better with a *chronic* condition like asthma, diabetes, or heart disease

Individual visits and all other covered *services* are provided at **no charge.** See "*Health Education*" in the "How to Get Care" section for other ways you can get *health education*.

To learn more, call our Member Service Call Center, log on to **kp.org**, or look in *Your Guidebook.*

Hearing Services

Hearing Tests

We cover tests at **no charge** to find out if you need a hearing aid and which hearing aid will be best for you.

Hearing Aids

We cover the following at **no charge** when prescribed by a *Kaiser Permanente plan doctor* or hearing specialist:

- One hearing aid, or one hearing aid for each ear if both are needed for results significantly better than you could get with one aid
- For each covered hearing aid, ear molds needed for fitting
- Visits to make sure that the aid is working right
- Visits for fitting and cleaning
- Repair of your hearing aid
- Hearing aid batteries

We cover a new hearing aid if:

- Your hearing loss is such that your current hearing aid is not able to correct it; or
- Your hearing aid is lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how this happened.

We will choose who will supply the aid. Coverage is limited to the lowest-cost aid that meets your medical needs.

Related *Services*

For more information about coverage for the following *service*s, see these headings in the "Benefits" section:

- *Services* related to the ear or hearing other than those described in this section, such as *outpatient care* to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Exclusion

We do not cover hearing aids that are implanted.

Home Health Care

Home health care is *services* you get in the home from:

- Nurses
- Medical social workers
- Home health aides
- Physical, occupational, and speech therapists

We cover home health *services* at **no charge** only if all of the following are met:

- You are housebound (substantially confined to your home or a friend's or family member's home).
- Your condition requires the *services* of a nurse, physical therapist, occupational therapist, or speech therapist.
- A *Kaiser Permanente plan doctor* finds that it is possible to monitor and control your care in your home.

- A *Kaiser Permanente plan doctor* finds that the *services* can be provided in a safe and effective way in your home.
- You get the *services* in the *Kaiser Permanente service area*.

Home health *services* are limited to *services* that *Medi-Cal* covers, such as:

- Part-time skilled nursing care
- Part-time home health aide
- Medical social services
- Medical supplies

The following *services* are covered only as listed in these headings in this "Benefits" section:

- Dialysis Care
- *Durable Medical Equipment*
- *Ostomy Supplies* and *Urological Supplies*
- Outpatient *Pharmacy Services*
- *Prosthetic Devices* and *Orthotic Devices*

Exclusions

We do not cover:

- Care that a family member or other layperson could provide in a safe and effective way in the home setting after getting training. This *exclusion* applies to care that would be covered if the care were provided by a qualified health care professional in a hospital, *skilled nursing facility*, intermediate care facility, or subacute care facility.
- Care in the home if the home is not a safe and effective treatment setting.

Hospice Care

Members who are dying can choose to get hospice care for their terminal illness. This care helps the discomforts of someone who is dying and also helps that person's caregiver and family.

If you choose hospice care:

- Adults age 21 years or older get care to relieve pain and other symptoms of their terminal illness, but not to cure the illness.
- Children under age 21 get care to relieve pain and other symptoms of their terminal illness and can choose to continue to get treatment for their illness.

You can change your choice to get hospice care at any time. Your choice to start or stop hospice care must be in writing and follow *Medi-Cal* rules.

We cover hospice care at **no charge** only if:

- A *Kaiser Permanente plan doctor* finds that you have a terminal illness and you are expected to live 12 months or less; and
- The *services* are provided in the *Kaiser Permanente service area* or inside California but within 15 miles or 30 minutes from the *Kaiser Permanente service area* (including in a friend's or

family member's home, or a facility we contract with if you are a resident of that facility); and

- The *services* are provided by a licensed hospice agency that is a *Kaiser Permanente plan provider*; and
- The *services* are needed for pain relief and management of your terminal illness and related conditions.

If the above is true, we cover these hospice *services*, which you can get on a 24-hour basis if needed for your hospice care:

- *Services* of *Kaiser Permanente plan doctors.*
- Skilled nursing care, such as evaluation and case management of nursing needs, treatment for pain and symptom control, emotional support for you and your family, and instructions for caregivers.
- *Physical therapy*, *occupational therapy*, or *speech therapy* for symptom control or to help you maintain activities of daily living.
- *Respiratory therapy.*
- Medical social services.
- Home health aide and help with eating, bathing, and dressing.
- Drugs for pain control and to help with other symptoms of your terminal illness, up to a 100-day supply for each refill in accord with our drug *formulary* guidelines. You must get these drugs at a *Kaiser Permanente plan pharmacy.* For some drugs, we cover a 30-day supply in any 30-day period. Call our Member Service Call Center for a list of these drugs.
- *Durable medical equipment*
- Respite care when needed to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five days in a row at one time.
- Counseling to help with loss.
- Advice about diet.
- Nursing care at home (for as much as 24 hours a day) or short-term inpatient care (at a level that cannot be provided at home) during periods of crisis when you need care for pain control all the time or management of *acute* medical symptoms.

Medical Transportation

Emergency Ambulance *Services*

We cover *services* of a licensed ambulance at **no charge** anywhere in the world without prior *authorization* (including transportation through the 911 emergency response system where available) if one of the following is true:

- A reasonable person would have believed that the medical condition was an *emergency medical condition* which required ambulance *services.*
- The doctor who is treating you finds that you must be moved to another

facility because your *emergency medical condition* is not *stabilized* and you cannot get the care you need at the treating facility.

If you get a bill or had to pay for emergency transport *services,* you must file a claim. Please refer to "How to file a claim" in the "Emergency Services and Urgent Care" section for information on how to file a claim.

Nonemergency Ambulance *Services*

Inside the *Kaiser Permanente service area*, we cover nonemergency ambulance and psychiatric transport van *services* at **no charge** if a *Kaiser Permanente plan doctor* finds that you need *services* that only a licensed ambulance (or psychiatric transport van) can provide and that the use of any other kind of transport might harm your health. These *services* are covered only when the vehicle transports you to or from covered *services*.

Other Medical Transportation *Services*

Inside the *Kaiser Permanente service area*, we cover a wheelchair van or gurney van at **no charge** if a *Kaiser Permanente plan doctor* finds that transport by car, taxi, or bus (or other public or private transport) might harm your health and *authorizes* a wheelchair van or gurney van in writing ahead of time because this transport is *medically necessary.* These *services* are covered only when they are needed to transport you to or from covered *services*.

Exclusion

We do not cover transport by car, taxi, or bus (or other public or private transport, other than a licensed ambulance or psychiatric transport van), even if it is the only way to get to a *Kaiser Permanente plan provider.*

Mental Health *Services*

We cover mental health *services* that you get from your *PCP* (*Primary Care Provider*) at **no charge.** *Services* your *PCP* can provide are limited to short-term care in a primary care setting. If you are age 12 or older, your parent may not have to give approval for you to get these *services.* To learn when the law requires your parent's approval, talk to your *Kaiser Permanente plan doctor*.

Other *Services*

If you need *specialty mental health services* or *Short-Doyle mental health services*, you must get this care from county mental health providers, except that we cover the following *services* as described in this "Benefits" section:

- Drugs related to *specialty mental health services* or *Short-Doyle mental health services*

- Imaging and lab tests related to *specialty mental health services* or *Short-Doyle mental health service*s

Exclusions

We do not cover:

- *Specialty mental health services* and *Short-Doyle mental health services* (except related drugs, imaging, and lab tests, as described above). You must get these *services* through the Los Angeles County Mental Health Department. Call toll free **1-800-854-7771** to learn more.
- *Services* that are not provided in a medical setting (residential treatment).

Ostomy Supplies and Urological Supplies

Ostomy supplies are *medically necessary* supplies that take waste out of the body. *Urological supplies* are *medically necessary* supplies that capture urine outside the body.

In the *Kaiser Permanente service area*, we cover *ostomy supplies* and *urological supplies* that are prescribed in accord with our soft goods *formulary* and *Medi-Cal* guidelines at **no charge.**

We select whom we will buy the supplies from. Coverage is limited to the lowest-cost item that meets your medical needs.

Our Soft Goods *Formulary*

Our soft goods *formulary* is a list of *ostomy supplie*s and *urological supplies* that have been approved by our Soft Goods *Formulary* Executive Committee for our *members*. The committee reviews and revises the list from time to time to keep up with changes in medical technology and clinical practice.

To find out if an *ostomy supply* or *urological supply* is on the list, call our Member Service Call Center. Our soft goods *formulary* guidelines allow you to get *ostomy supplies* and *urological supplies* that are not on the list if they are otherwise covered and the *Medical Group* finds that the item is *medically necessary*.

Exclusion

We do not cover luxury items.

Outpatient Imaging, Lab Tests, and Special Procedures

We cover imaging, lab tests, and special procedures prescribed by a *Kaiser Permanente plan provider* as part of care covered under headings in this "Benefits" section at **no charge:**

- Imaging to help find out what is wrong and for treatment:
  - X-rays
  - mammograms
  - ultrasound

- MRIs
- CT scans
- PET scans

- Preventive imaging, such as preventive mammograms, aortic aneurysm screenings, and bone density screenings
- Nuclear medicine
- Lab tests, including:
  - diabetes, cardiovascular disease, cervical cancer screening tests including human papillomavirus (HPV), prostate-specific antigen tests, sexually transmitted disease (STD) tests, and HIV tests
  - tests for genetic disorders for which you can get genetic counseling
- Other diagnostic procedures, such as those that check the heart (EKGs) or brain (EEGs)
- Radiation therapy
- UV (ultraviolet) light treatment
- Retinal photography screenings

We cover lab tests and special procedures prescribed by a *non–Kaiser Permanente plan provider* at **no charge** only if the *services* are related to:

- *Specialty mental health services* and *Short-Doyle mental health services*
- Covered *family planning services*
- Covered *sensitive services*
- Covered *emergency services* and *post-stabilization care*
- Covered *out-of-area urgent care*

Outpatient *Pharmacy Services*

We cover the drugs and items listed in this section when prescribed as follows and obtained at a *Kaiser Permanente plan pharmacy* or through our mail-order service:

- Items prescribed by *Kaiser Permanente plan doctors* in accord with our drug *formulary* guidelines.
- Items prescribed by the following *non–Kaiser Permanente plan providers* unless a *Kaiser Permanente plan doctor* finds that the item is not *medically necessary* or the drug is for a sexual dysfunction disorder:
  - dentists if the drug is for dental care.
  - *non–Kaiser Permanente plan doctors* if the *Medical Group authorizes* a written *referral* to the *non–Kaiser Permanente plan doctor* and the item is covered as part of that *referral.*
  - *non–Kaiser Permanente plan doctors* if the item is covered *emergency services*, *post-stabilization care*, or *out-of-area urgent care*
  - *non–Kaiser Permanente plan doctors* if the drug is related to *specialty mental health services* or *Short-Doyle mental health services.*

See "Using the Pharmacy" in the "How to Get Care" section to learn how to get covered items.

Administered Drugs and Items

Administered drugs, supplies, and supplements are drugs or items you get in a *Kaiser Permanente plan medical office* or during home visits when the drug must be given (administered) or observed by medical staff. We cover the following administered drugs and items at **no charge:**

- Radioactive materials used for treatment
- Vaccines and shots (immunizations)
- Allergy tests and treatments

Contraceptive Drugs and Items

We cover the following contraceptive drugs and items at **no charge:**

- Birth control drugs that go on or under the skin
- IUDs (intrauterine devices)
- Birth control pills (including *emergency contraceptives*)
- Diaphragms
- Cervical caps, contraceptive rings and patches
- Contraceptive creams, foams, and jellies
- Condoms

Self-administered Drugs and Items

Self-administered drugs, supplies, and supplements are drugs or items that you take (self-administer) at home.

We cover self-administered IV drugs, fluids, additives, and nutrients that require infusion (such as IV or intraspinal infusion) when prescribed by a *Kaiser Permanente plan doctor* at **no charge** for up to a 30-day supply per refill. We also cover supplies needed to administer these drugs and items at **no charge.**

We cover the following self-administered drugs and items when prescribed by a *Kaiser Permanente plan doctor* at **no charge** for up to a 100-day supply per refill:

- Prescription drugs
- Other drugs that *Medi-Cal* covers, such as vitamins when you are pregnant
- Drugs to help you stop smoking or chewing tobacco, if you take part in a *health education* program that the *Medical Group* approves
- Disposable needles needed for covered drugs
- Inhaler spacers needed to inhale covered drugs

We cover the following self-administered items when prescribed by a *Kaiser Permanente plan doctor* at **no charge** for up to a 30-day supply per refill in any 30-day period:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Elemental dietary enteral formula

If we amend this *Member Handbook* to exclude a drug that we have been covering and providing to you under this *Member Handbook*, we will keep providing the drug at **no charge** if a prescription is required by law and a *Kaiser Permanente plan doctor* keeps prescribing the drug for the same condition for a use approved by the *FDA* (*Food and Drug Administration*).

We also cover the following *medically necessary* drugs at **no charge** when prescribed by *non–Kaiser Permanente plan providers*:

- Drugs related to dental care that are prescribed by dentists.
- Drugs related to covered *emergency services*, *post-stabilization care*, and *out-of-area urgent care.*
- Drugs and items related to covered *family planning services.*
- Drugs related to covered *sensitive services.*
- Drugs related to *specialty mental health services* and *Short-Doyle mental health services.*

Diabetes Urine-testing Supplies

We cover the following items at **no charge:**

- Test strips
- Test tablets or tapes

Insulin-administration Devices

We cover the following items at **no charge:**

- Disposable needles
- Pen devices
- Visual aids needed to see the dose

Day Supply Limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. *Kaiser Permanente plan doctors* decide the amount of a drug, supply, or supplement that is a *medically necessary* 30- or 100-day supply for you. The amount of drugs and items you get per refill (the day supply limit) is listed in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. Amounts of drugs or items in excess of the day supply limit are not covered.

The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy finds that the item is in limited supply in the market or for specific drugs (your *Kaiser Permanente plan pharmacy* can tell you if a drug you take is one of these drugs).

Our Drug *Formulary*

Our drug *formulary* is a list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our *members.* They choose drugs for the list using factors such as how safe the drug is and how well it works. They meet every three months to see if drugs need to be added or taken off the list. They can make changes to the list if

there are new facts about a drug or if there is a new drug.

To get a copy of our drug *formulary*, call our Member Service Call Center. To get the *Medi-Cal* drug *formulary*, call *L.A. Care* Member Services toll free at **1-888-839-9909**. Note: The fact that a drug is on the list does not necessarily mean that your *Kaiser Permanente plan doctor* will prescribe it for a particular medical condition.

Our drug *formulary* guidelines say:

- You can get drugs that are not on the list if they would otherwise be covered and a *Kaiser Permanente plan doctor* finds that the drug is *medically necessary*. If your *Kaiser Permanente plan doctor* finds that one of these drugs is not *medically necessary* and you disagree, you can file a *grievance.*
- You must take part in a *health education* program for some conditions.

Related *Services*

For more information about coverage for the following *services*, see these headings in the "Benefits" section:

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "*Durable Medical Equipment* ")
- *Durable medical equipment* used to administer drugs (refer to "*Durable Medical Equipment* for Home Use")
- Outpatient administered drugs (refer to "*Outpatient Care*")
- Drugs covered during a covered stay in a *Kaiser Permanente Plan Hospital* or *Kaiser Permanente Plan skilled nursing facility* (refer to "*Hospital Inpatient Care*" and "*Skilled Nursing/Intermediate/Subacute Facility* ")
- Drugs prescribed for pain control and symptom management of the terminal illness for *Members* who are receiving covered hospice care (refer to "Hospice Care")

Exclusion

We do not cover special packaging.

Prosthetic Devices and Orthotic Devices

Prosthetic devices are *medically necessary* items that replace all or part of an organ or limb. *Orthotic devices* are *medically necessary* items that support or correct a body part.

We cover the *prosthetic devices* and *orthotic devices* if they are:

- In general use.
- For repeated use.
- Used for a medical purpose.
- Not useful to someone who is not ill or hurt.

We cover *prosthetic devices* and *orthotic devices* only in the *Kaiser Permanente service area*. Coverage is limited to the lowest-cost

item that meets your medical needs. We cover *services* to find out if you need an item. We decide who will supply and repair the item. We cover visits to fit and adjust the item. We will fix or replace the item unless you lose or misuse it.

Internally Implanted Devices

We cover items implanted during a covered surgery at **no charge.**

External Devices

We cover the following items at **no charge:**

- *Prosthetic devices* to restore a way of speaking after all or part of the larynx has been removed
- Breast prostheses after a *medically necessary* removal of a breast, including custom-made items when *medically necessary* and up to three bras required to hold a prosthesis each year.
- *Medically necessary* footwear to prevent or treat problems related to diabetes.
- Burn wraps and wraps for swelling after lymph nodes have been removed.
- Enteral formula for *members* who need tube feeding in accord with *Medicare* guidelines.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.
- *Prosthetic devices* needed to replace an organ or limb, but only if they also replace the function of the organ or limb.
- *Orthotic devices* needed to support or correct a body part.
- Braces and special shoes if they are attached to the brace.
- Special footwear for foot disfigurement due to disease, injury, or developmental disability.

Related *Services*

For more information about coverage for the following *services,* see these headings in the "Benefits" section:

- Contact lenses to treat aniridia (refer to "Vision *Services*")

Exclusions

We do not cover:

- Dental appliances.
- Multifocal intraocular lenses.
- Monofocal intraocular lenses to correct astigmatism.
- Items that are not rigid, such as stockings and wigs (unless *Medi-Cal* criteria have been met).
- Luxury items.
- Shoes or arch supports that are not *medically necessary* (except special footwear as described above).

Reconstructive Surgery

Reconstructive surgery is *services* to correct or repair problems with parts of the body that are caused by birth defects, abnormal development, trauma, infection, tumors, or disease.

The *services* are covered at **no charge** if a *Kaiser Permanente plan doctor* finds that they will:

- Make your body work better, or
- Make a more normal look.

After *medically necessary* removal of all or part of a breast, we cover *reconstructive surgery* of the breast and *reconstructive surgery* of the other breast for a more similar look. We cover *services* for swelling after lymph nodes have been removed.

Related *Services*

For more information about coverage for the following services, see these headings in the "Benefits" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Lab Tests, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Pharmacy Services")
- Outpatient administered drugs (refer to "*Outpatient Care*")
- Prosthetics and orthotics (refer to "*Prosthetic Devices* and *Orthotic Devices*")

Exclusions

We do not cover surgery:

- If a *Kaiser Permanente plan doctor* finds that it will cause only a small change in how you look.
- On normal parts of the body to change how you look.

Sensitive Services

Sensitive services are *medically necessary services* for family planning, STDs (sexually transmitted diseases), HIV/AIDS, sexual assault, and abortions.

If you are age 12 or older, your parent does not have to give approval for you to get these *services*. To learn when the law requires your parent's approval, talk to your *Kaiser Permanente plan doctor*.

Family Planning *Services*

See "*Family Planning Services*" and "Outpatient *Pharmacy Services*" in this "Benefits" section for coverage for *family planning services*.

STD *Services*

We cover the first visit for STD *services* from a *Kaiser Permanente plan doctor* or from a *non–Kaiser Permanente plan provider* that accepts *Medi-Cal* at **no charge.** Your *PCP* (*Primary Care Provider*) does not have to *authorize* these *services*. We will pay the

non–Kaiser Permanente plan provider for the covered *services* that you get.

You must get most follow-up *services* from a *Kaiser Permanente plan doctor*. You can get some follow-up *services* from the local health department or a *family planning services* provider, as allowed by the *California Department of Health Care Services*.

HIV/AIDS *Services*

We cover the first visit for HIV/AIDS *services* from a *Kaiser Permanente plan doctor* or from a *non–Kaiser Permanente plan provider* that accepts *Medi-Cal* at **no charge.** Your *PCP* (*Primary Care Provider*) does not have to *authorize* these *services*. We will pay the *non–Kaiser Permanente plan provider* for the covered *services* that you get.

If you need treatment for HIV/AIDS, you must get these *services* from a *Kaiser Permanente plan doctor*.

Services Related to Sexual Assault

Services related to sexual assault are covered under "*Outpatient Care*" and "*Hospital Inpatient Care*" in this "Benefits" section. Your *PCP* (*Primary Care Provider*) does not have to *authorize* these *services*. We will pay the *non–Kaiser Permanente plan providers* for the covered *services* that you get.

Abortions

We cover outpatient and inpatient abortions at **no charge** when we arrange for the services. Your *PCP* (*Primary Care Provider*) does not have to *authorize* these outpatient *services.*

You can also get these outpatient *services* from a *non–Kaiser Permanente plan provider* that accepts *Medi-Cal*. We will pay the provider for the outpatient *services* you get.

Services Related to Clinical Trials

We cover *services* that are related to a cancer *clinical trial* at **no charge** if all of the following are met:

- You have been diagnosed with cancer.
- You are accepted into a *clinical trial* for cancer.
- The *Kaiser Permanente plan doctor*, or your *non–Kaiser Permanente plan doctor* if the *Medical Group authorizes* a written *referral* to the *non–Kaiser Permanente plan doctor* for treatment of cancer, thinks that the *clinical trial* will benefit you. To learn more about *referrals* to *non–Kaiser Permanente plan providers,* please see the "Getting a Referral" section.
- The *services* are covered in this *Member Handbook.*
- The *clinical trial* is to treat cancer and not just to find out if a drug is safe.

- The *clinical trial* must involve a drug that does not need a new drug application or be approved by the National Institutes of Health, the *FDA,* the Department of Defense, or the Department of Veterans Affairs.

Exclusions

We do not cover:

- *Services* that are provided only for data collection and analysis.
- *Services* that someone in a *clinical trial* usually gets from the sponsors of the trial free of charge.
- *Services* related to drugs or items that have not been approved by the *FDA*.

Skilled Nursing/Intermediate/ Subacute Facility Care

In the *Kaiser Permanente service area*, we cover *services* for the month of admission and the next month in a *Kaiser Permanente plan skilled nursing facility,* intermediate care facility, or subacute care facility that we contract with. The *services* must be *medically necessary* and must be prescribed by a *Kaiser Permanente plan doctor.* You do not need to be in a hospital before you get the *services.*

The *services* must be at a level of care that people normally get in a *skilled nursing facility*, intermediate care facility, or subacute care facility:

- Skilled *services*
- Subacute *services*, in accord with *Medi-Cal* standards
- Custodial care *services*, in accord with *Medi-Cal* standards

We cover the following at **no charge:**

- *Services* of *Kaiser Permanente plan doctors*
- Nursing *services*
- Room and meals
- Drugs prescribed by *Kaiser Permanente plan doctors* as part of your plan of care in the *Kaiser Permanente plan skilled nursing facility* in accord with our drug *formulary* if they are given to you in a *Kaiser Permanente plan skilled nursing facility* by medical personnel
- *DME* in accord with our *DME formulary* if *skilled nursing facilities* generally furnish the equipment
- Imaging, lab services, and special procedures that *skilled nursing facilities* normally provide
- Medical social services
- Blood and blood products
- Medical supplies
- *Physical therapy*, *occupational therapy*, and *speech therapy*
- *Respiratory therapy*

If you need *skilled nursing facility* care, intermediate facility care, or subacute care longer than the month of admission plus the next month, you will be disenrolled and

get this care through *regular Medi-Cal*. You will not be disenrolled if you are getting covered hospice care.

Related *Services*

For more information about coverage for the following *services*, see these headings in the "Benefits" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Lab Tests, and Special Procedures")

Transplant Services

We cover corneal transplants at **no charge** if the transplant is not covered by *California Children's Services* (*CCS*).

We also cover kidney transplants at **no charge** if the *Medical Group* gives you a written *referral* to a transplant facility and the transplant is not covered by *CCS.*

After the *referral,* if the *Medical Group* or the *referral* facility finds that you do not meet the criteria for a transplant, we will pay only for *services* that you get before that finding is made. We are not responsible for making sure an organ is available. We cover certain *services* for a donor or someone the *Medical Group* finds might be a donor (whether or not the donor is a *member*). The *services* must be in accord with our guidelines for *services* for living transplant donors and must be related to your covered transplant. These *services* may include harvesting the organ, tissue, or bone marrow and for treatment of complications. To get a copy of the guidelines for *services* for living donors, call our Member Service Call Center.

Exclusions

We do not cover kidney or corneal transplants for *members* up to age 21 if *CCS* covers the transplant. See "California Children's Services" under "Exclusions" in the "Exclusions, Limitations, and Reductions" section to learn more about what happens when a transplant is covered by *CCS.*

We do not cover any transplant, other than kidney or corneal, for *members* of any age:

- If you are under age 21, *CCS* may cover the transplant. See "California Children's Services" under "Exclusions" in the "Exclusions, Limitations, and Reductions" section to learn more about what happens when a transplant is covered by *CCS.*
- If *CCS* does not cover the transplant and if the *Medical Group* gives you a written *referral* to a *Medi-Cal* transplant center for evaluation for a transplant that we do not cover, we will pay for *services* to find out if you meet the criteria for the transplant. If you meet the criteria and *Medi-Cal authorizes* the transplant, you will be disenrolled from *Medi-Cal managed care* and get the *services* through *regular Medi-Cal.* If you

do not meet the *CCS* criteria, you will remain enrolled in *Kaiser Permanente.*

Vision Services

We cover vision *services* listed below when you get the *services* at a *Kaiser Permanente plan medical office* or *Kaiser Permanente Plan Optical Sales Office* and the *services* are prescribed by a *Kaiser Permanente plan doctor* or *Kaiser Permanente plan optometrist*.

Eye Exams

Vision exams to find out if you need eyeglasses and to provide a prescription for eyeglasses.

Eyeglasses

Eyeglasses (frame and lenses) if you are under age 21 as follows:

- We provide an $80 *allowance* for eyeglass frames if you have a prescription of at least 0.75 diopter.
- We provide an $80 *allowance* for replacement eyeglass frames every 24 months if:
  - you have a change in prescription of at least 0.50 diopter; or
  - your eyeglasses are lost, stolen, or broken (and cannot be fixed), and it was not your fault. You must give us a note that tells us how your eyeglasses were lost, stolen, or broken. The replacement frames will be the same style as your old frames (up to $80) if less than 24 months have passed since you got your eyeglasses.
- For new or replacement eyeglasses, eyeglass lenses are provided by the state.

If you choose frames that cost $80 or less, the eyeglasses are provided at **no charge**. If you choose frames that cost more than $80, you must pay the difference between the $80 *allowance* and the cost of the frames. The frame *allowance* can only be used when you order your eyeglasses. If you do not use the whole *allowance* when you order your eyeglasses, you cannot use it later.

Special Contact Lenses

We cover the following special contact lenses:

- Up to two *medically necessary* contact lenses, fitting, and dispensing per eye every 12 months to treat aniridia (missing iris) at **no charge.**
- One pair of *medically necessary* contact lenses every 24 months for *members* under age 21 at **no charge**. Contact lenses are covered only if a *Kaiser Permanente plan doctor* or *Kaiser Permanente plan optometrist* finds that they will give you much better vision than you could get with eyeglasses alone. We cover replacement of *medically necessary* contact lenses if your contact lenses are lost or stolen. You

must give us a note that tells us how your contact lenses were lost or stolen.

Related *Services*

For more information about coverage for the following *services,* see these headings in this "Benefits "section:

- Services related to the eye or vision other than *Services* covered under this "Vision *Services*" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits " section)

Exclusions

We do not cover:

- Frames, if you have frames that can be used.
- Lenses, other than those we get from the state, unless *medically necessary.*
- Eye surgery to fix not being able to see near, far, or blurred vision.
- Frames for safety glasses.
- Sunglasses.
- Tinted lenses, unless *medically necessary* to treat macular degeneration or retinitis pigmentosa.
- Cosmetic contact lenses and related *services.*
- Lens adornment.
- Low-vision devices, unless *Medi-Cal* criteria have been met for members who are under the age of 21 years.
- Items that do not need a prescription, such as cases and repair kits.

Other Programs for People with *Medi-Cal*

Early Start

Early Start is a program that covers special *services* for children up to age 3 who are at risk for developing slower than other children. Talk to your *Kaiser Permanente plan doctor* to learn more.

Federally Qualified Health Centers (FQHC)

People with *Medi-Cal* can get health care at a *Federally Qualified Health Center* (*FQHC*). If you want to get your health care at an *FQHC* on a regular basis, you must change plan partners and choose an *FQHC* doctor as your *PCP* (*Primary Care Provider*) through an *L.A. Care* plan partner that has the *FQHC* as part of their network. When the change happens, you must get all of your care from *non–Kaiser Permanente plan providers*. Call *L.A. Care* Member Services toll free at **1-888-839-9909** to learn more.

Indian Health Centers

If you are a Native American, you can get health care at an *Indian Health Center*. If you want to get your health care from one of these clinics on a regular basis, please contact your local *Indian Health Center,* listed in your phone book. If you would like to receive all of your primary health care from an *Indian Health Center*, please contact *L.A. Care Health Plan* at **1-888-4LA-CARE** (**1-888-452-2273**) for help. You may be able to disenroll from *Medi-Cal managed care* and get your health care at an *Indian Health Center* through *regular Medi-Cal*. Please call *Health Care Options* toll free at **1-800-430-4263** for disenrollment information.

Medi-Cal Fee-for-Service (Regular *Medi-Cal*)

Kaiser Permanente does not cover all the *services* that *Medi-Cal* covers. If we do not cover a *service* that *Medi-Cal* covers, you must get the *services* through *regular Medi-Cal* or other programs. In most cases, like *CCS*, your *Kaiser Permanente plan provider* will refer you to a *non–Kaiser Permanente plan provider*. In some cases, like dental care, you can go directly to a *non–Kaiser Permanente plan provider*.

To learn more about how to get the following *services* that are covered by *regular Medi-Cal*, call your County Eligibility Worker or *Medi-Cal* toll free at **1-800-430-4263** (English) or **1-800-430-3003** (Spanish):

- Acupuncture
- Chiropractic
- Local education agency assessment services
- Major organ transplants, except kidney and corneal transplants, that are not

covered by *CCS* (see "*Exclusions*" under "Transplant Services" in the "Benefits" section for more information about what happens when a transplant is not covered by *CCS*)

- Prayer healing

You can go directly to a *non–Kaiser Permanente plan provider* for the following *services*:

- Chemical dependency (outpatient)
- Dental services

Regional Centers

People with developmental disabilities can get counseling, support, and other nonmedical *services* from a *Regional Center.*

Call one of these *Regional Centers* to learn more:

- East Los Angeles **1-626-299-4700**
- Frank D. Lanterman..... **1-213-383-1300**
- Harbor..... **1-310-540-1711**
- North Los Angeles **1-818-778-1900**
- San Gabriel/Pomona **1-909-620-7722**
- South Central Los Angeles..... **1-213-763-7800**
- Westside **1-310-258-4000**

Women, Infants, and Children (WIC) Program

The WIC Program helps pregnant women and young children eat well and stay healthy. Talk to your *Kaiser Permanente plan doctor* or call the WIC Program toll free at **1-888-942-9675** to learn more.

Exclusions, *Limitations*, and *Reductions*

Exclusions

The items and services listed in this "Exclusions" section are not covered by *Kaiser Permanente*. These exclusions apply to all *services* that would otherwise be covered under this *Member Handbook*, even if the items and services are within the scope of a provider's license or certificate. Other *exclusions* that apply only to one *service* are listed in the description of that *service* in the "Benefits" section.

Acupuncture *Services*

You must get these *services* through *regular Medi-Cal*.

Artificial Insemination, Infertility Services, and Conception by Artificial Means

Services that help someone get pregnant.

California Children's Services

Services that you get through the *California Children's Services* (*CCS*) program. *CCS* covers special *services* for people up to age 21 with serious or *chronic* conditions. Some examples of *CCS*-eligible *services* are doctor visits, surgery, lab tests and X-rays, hospital stays, cochlear implants, osseointegrated hearing aids, and contact lenses to treat aphakia and aniridia. If you are under age 21, and a *Kaiser Permanente plan doctor* thinks you have an eligible condition, you will be referred to *CCS*.

CCS will evaluate your condition and determine if you are eligible to get *services*. *Kaiser Permanente* will continue to provide covered *services* while *CCS* is determining your eligibility.

If *CCS* determines that you are eligible for *CCS*:

- You must get *services* related to the *CCS* condition from *CCS* providers.
- *CCS* will let you know which doctors and facilities are *authorized* to treat your *CCS*-eligible condition.
- You will continue to get all covered *services* not related to the *CCS* condition from *Kaiser Permanente.*

If *CCS* determines that you are not eligible, *Kaiser Permanente* will continue to provide covered *services*.

Talk to your *Kaiser Permanente plan doctor* or your local *CCS* office to learn more about *services* that *CCS* covers and the *CCS* authorization process.

Certain Case Management Services

The following are case management *services:*

- Lead poisoning case management *services*. You must get these *services* from the local health department. This *exclusion* does not apply to covered

treatment for lead poisoning, which is provided by *Kaiser Permanente.*

- Targeted case management *services*. You must get these *services* from the local governmental health programs/agencies and *Regional Centers*. This exclusion does not apply to covered *services* provided by Kaiser Permanente that are *medically necessary*.

Certain Exams and Services

Exams and *services* needed:

- To get or keep a job
- To get insurance
- To get any kind of license
- By order of a court, or if for parole or probation

This *exclusion* does not apply if a *Kaiser Permanente plan doctor* finds that the *services* are *medically necessary*.

Certain Services for Tuberculosis (TB)

Some TB *services* (directly observed therapy). You must get these *services* through the local health department.

Chiropractic S*ervices*

You must get these *services* through *regular Medi-Cal*.

Comfort or Convenience Items

Items that are solely for the comfort or convenience of a *member*, a *member's* family, or a *member's* health care provider.

Cosmetic S*ervices*

Services to change the way you look. This *exclusion* does not apply to:

- *Services* covered under "*Reconstructive Surgery*" in the "Benefits" section
- The following devices covered under "*Prosthetic Devices* and *Orthotic Devices*" in the "Benefits" section: testicular implants implanted as part of a covered *reconstructive surgery*, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part.

Dental Care

Services that are normally done by a dentist, orthodontist, or oral surgeon. Excluded dental care also includes dental appliances. You must get dental *services* through Denti-Cal. To learn more, call toll free **1-800-322-6384**. This *exclusion* does not apply to *services* covered under "Dental Services for Radiation Treatment and Dental Anesthesia" in the "Benefits" section.

Disposable Supplies

The following disposable supplies for home use: bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages.

This *exclusion* does not apply to disposable supplies covered under "Dialysis Care," "*Durable Medical Equipment*," "Home Health Care," "Hospice Care," "*Ostomy Supplies* and *Urological Supplies*," and "Outpatient *Pharmacy Services*" in the "Benefits" section.

Experimental or Investigational Services

A *service* that we, with input from the *Medical Group*, find one of the following is true:

- Is not seen as safe and effective by generally accepted medical standards to treat a condition (even if it has been authorized by law for use in testing or other studies on human patients)
- Has not been approved by the government to treat a condition

This *exclusion* does not apply to the following:

- *Experimental or investigational services* when an investigational application has been filed with the *FDA* and the manufacturer or other source makes the *services* available to you or *Kaiser Permanente* through an *FDA*-authorized procedure. We do not cover *services* that are customarily provided by research sponsors free of charge to enrollees in a *clinical trial* or other investigational treatment protocol.
- *Services* covered under "*Services* Related to *Clinical Trials*" in the "Benefits" section.

See "*Independent Medical Review*" in the "How to Solve Problems" section to learn about *independent medical review* of requests for *experimental or investigational services*.

Hair Loss or Growth Treatment

Items and services to make hair grow or for hair loss.

Items and Services That Are Not Health Care Items and Services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses

- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy

Local Education Agency Assessment Services

Services that you get through schools. You must get these *services* through *regular Medi-Cal*.

Massage Therapy

Personal Care Services

Services that are not *medically necessary*, such as help with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This *exclusion* does not apply to assistance with activities of daily living that is provided as part of covered Skilled Nursing/Intermediate/Subacute Facility Care or Hospice Care.

Prayer Healing

Services of Christian Science providers. You must get these *services* through *regular Medi-Cal*.

Reversal of Sterilization

Services to reverse voluntary surgical birth control.

Routine Foot Care Items and Services

Foot care items and services that are not *medically necessary*.

Services Not Approved by the *FDA*

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other *services* that by law require federal *Food and Drug Administration* (*FDA*) approval in order to be sold in the U.S. but are not approved by the *FDA*. This *exclusion* applies to *services* provided anywhere, even outside the U.S.

This *exclusion* does not apply to the following:

- *Services* covered under the "*Emergency Services* and *Urgent Care*" section that you receive outside the U.S.
- *Experimental or investigational services* when an investigational application has been filed with the *FDA* and the manufacturer or other source makes the *services* available to you or *Kaiser Permanente* through an *FDA*-authorized procedure. We do not cover *services* that are customarily provided by research sponsors free of charge to enrollees in a *clinical trial* or other investigational treatment protocol.
- *Services* covered under "*Services* Related to *Clinical Trials*" in the "Benefits" section.

See "*Independent Medical Review*" in the "How to Solve Problems" section to learn

about *independent medical review* of requests for *experimental or investigational services*.

Services Performed by Unlicensed People

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the *member's* condition does not require that the services be provided by a licensed health care provider.

Services Related to a Noncovered Service

When a *service* is not covered, all *services* related to the noncovered *service* are excluded. This *exclusion* does not apply to:

- *Services* we would otherwise cover to treat complications of the noncovered *service* (for example, if you have a noncovered cosmetic surgery, we would not cover *Services* you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply, and we would cover any *Services* that we would otherwise cover to treat that complication).
- Drugs and lab tests related to *specialty mental health services* and *Short-Doyle mental health services.*

Short-Doyle Mental Health Services

Certain *medically necessary services* for severe *chronic* mental illness that may require a long-term hospital stay. You must get these *services* from the Los Angeles County Mental Health Department. Call toll free **1-800-854-7771** to learn more.

Speech Therapy

Speech therapy services to treat social, behavioral, or cognitive delays in speech or language development. This *exclusion* does not apply if the *services* are *medically necessary*.

Travel and Lodging Costs

Travel and lodging costs. This *exclusion* does not apply to:

- Some situations if the *Medical Group* refers you to a *non–Kaiser Permanente plan provider*. We must *authorize* the costs ahead of time in accord with our travel and lodging guidelines. You can get these guidelines from our Member Service Call Center.
- *Services* covered under "Medical Transportation" in the "Benefits" section.

Vision *Services*

Vision *services* for *members* age 21 or older, which include:

- Frames and lenses.

- Contact lenses, except for *medically necessary* contact lenses to treat aniridia.

Waiver Programs

Services that you get through waiver programs. Waiver programs provide care at home for people who would otherwise be in an institution. To get a complete listing or to learn more about *Medi-Cal* Waivers, visit the *California Department of Health Care Services (DHCS*) – *Medi-Cal* Waivers website.

You can get *services* through these waiver programs while still enrolled:

- AIDS Waiver
- DDS (Department of Developmental Services) Waiver
- Multipurpose Senior Services Program
- Nursing Facility/Acute Hospital Waiver

Limitations

If something happens that limits our ability to provide and arrange for care, like a major disaster, we will make a good-faith effort to provide you with the care that you need with *Kaiser Permanente plan providers* and *Kaiser Permanente plan facilities* that are available. If you have an *emergency medical condition*, go to the nearest hospital. You have coverage for *emergency services* as described in the "*Emergency Services* and *Urgent Care*" section.

Additional *limitations* that apply only to a particular *service* are listed in the description of that *service* in the "Benefits" section.

Reductions

The cost of *services* listed below is paid by some other source (a third party). In some cases, the *California Department of Health Care Services* (*DHCS*) has a right to recover money from the third party. If *DHCS* does not recover these costs, *Kaiser Permanente* can do so.

DHCS can ask a third party to pay for *services* that you get from *Kaiser Permanente* if:

- You are hurt on the job (workers' compensation).
- You are sick or hurt due to someone else, such as a car accident (third-party liability).
- There is money owed through your estate (estate recovery).

In cases when *DHCS* can ask a third party to pay for *services,* we will provide any *medically necessary services.* We will let *DHCS* know about the third party's action if we know about it. If the third party pays you money, you may have to pay *DHCS* for *services* that we paid for or gave to you.

Services Covered by an Employer

We will not pay for *services* that your employer must provide to you by law. When we provide any of these *services*, we may ask your employer to pay us back for the cost of these *services*.

Services Covered by Government Agencies

We will not pay for *services* that a government agency must provide by law. When we provide any of these *services*, we may ask the agency to pay us back for the cost of these *services*.

Services Covered by *Medicare*

If you are eligible for *Medicare*, you must let us know. The *Medicare* program may have to pay for certain *services* that you get from us. *Medi-Cal* always pays last.

Services Covered by the U.S. Department of Veterans Affairs

We will not pay for *services* needed due to military service that the Department of Veterans Affairs (VA) must provide by law. When we provide any of these *services*, we may ask the VA to pay us back for the cost of these *services*.

How to Solve Problems

There are many ways to solve problems. Read this section to find out about:

- The *Kaiser Permanente* G*rievance* Process
- The *L.A. Care* G*rievance* Process
- *State Hearing*
- *California Department of Managed Health Care* Complaints
- *Independent Medical Review*
- *Binding Arbitration*
- *California Department of Health Care Services* Office of the Ombudsman
- *Medi-Cal* Fraud

The *Kaiser Permanente* Grievance Process

We want you to be satisfied with the health care you get from *Kaiser Permanente*. We want to solve any issues you have promptly. If you have a concern, talk to our Member Services staff at your local *Kaiser Permanente plan facility* or at our Member Service Call Center. You can call our Member Service Call Center toll free weekdays 7 a.m.–7 p.m., weekends 7 a.m.–3 p.m. (except holidays):

- English **1-800-464-4000**
- Spanish..... **1-800-788-0616**
- Chinese dialects.....**1-800-757-7585**
- TTY.....**1-800-777-1370**

For help in other languages, please call our Member Service Call Center toll free at **1-800-464-4000** and ask for an *interpreter*.

Standard Process

If you are not satisfied for any reason, you can file a *grievance*. For example, you can file a *grievance* if:

- You believe a decision about coverage is wrong.
- You are not happy with *services* you got.
- You requested *services* and got a denial letter.
- You submitted a claim for *services* described in the "*Emergency Services* and *Urgent Care*" section and you did not agree with our decision and want to appeal.
- Your linguistic needs were not met.

There are two time frames in which you can file a *grievance*:

- If you receive a Notice of Action and you do not agree with the action, you must file a *grievance* within 90 days. A Notice of Action is a formal letter telling you that a medical service has been denied, deferred, or modified.
- For *independent medical review* (*IMR*) and all other *grievances,* you must file within 180 days of the denial or event or action

that caused you to be unhappy with the *service* or care you got.

You can file a *grievance* by telling us or writing us as follows:

- If you did not agree with our decision on a claim for *services* described in the "*Emergency Services* and *Urgent Care*" section, you may file an appeal. If you want to appeal our decision, you can submit your *grievance* in one of the following ways:
  - to the Claims Department at the following address:

    Kaiser Foundation Health Plan, Inc.
    Special Services Unit
    P.O. Box 7004
    Downey, CA 90242-7004

  - by calling our Member Service Call Center at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**).
- For all other issues, you can submit your *grievance* in one of the following ways:
  - to the Member Services Department at a *Kaiser Permanente plan facility*. See the "How to Get Help" section for addresses of Member Services offices;
  - by calling our Member Service Call Center at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). Member Services staff can also help you write the *grievance*, if needed.
  - through our website at **kp.org.**

After you file a *grievance*, we will send you a letter within five days letting you know we got it. The letter will tell you more about the *grievance* process. If your *grievance* is about our decision to end *services*, you may still get *medically necessary services* ordered by your *Kaiser Permanente plan doctor*.

After we get your *grievance*, we will let you know in writing within 30 days what we decided.

If we do not approve your request, we will tell you why. We will also tell you other ways to solve the problem.

Note: If you call us to file an administrative *grievance* and we fix the problem by the next business day, we will call you with our decision. If we call you, you may not get a letter.

Faster (Expedited) Process

You or your doctor can ask us to review your request faster. We will do this if your request is for a problem that needs to be taken care of quickly and is a serious threat to your health, such as severe pain or potential loss of life, limb, or major body function. We will let you know within 72 hours (orally or in writing) if we will provide the *services*.

We will also decide your *grievance* faster if the request is to keep a course of treatment

going that is ending soon. You must make the request at least 24 hours before the treatment ends, and we will let you know within 24 hours.

You or your doctor can ask for a faster review in one of these ways:

- Call our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**). They are available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message, and we will return your call the next business day.
- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
  Attention: Expedited Review
- Fax a request to our Expedited Review Unit toll free at **1-888-987-2252.**
- Go to the Member Services office at your local *Kaiser Permanente plan facility*.

Make sure to tell us that you want us to decide your *grievance* faster.

If we do not approve your request for a faster decision, we will let you know in writing. We will then respond to your request within 30 days using the standard *grievance* process (as described above).

If we do not approve your *grievance*, we will let you know in writing. The letter will tell you why we did not approve your *grievance* and other ways to solve the problem.

If you have an issue that involves an immediate and serious threat to your health (such as severe pain or potential loss of life, limb, or major body function), you can contact the *California Department of Managed Health Care* at any time without first filing a *grievance* with us. See "*California Department of Managed Health Care* Complaints" below.

Support for Your Grievance

If you can, include with your *grievance* facts that support your position. You should also include medical records from any *non–Kaiser Permanente plan providers* you have seen. If you do not have a copy of these records, we will ask you to authorize the release of the records in writing. If we do not get the records we ask for promptly, we will decide your request using the facts that we have.

Who Can File a Grievance

These people can file a *grievance:*

- You can file for yourself.
- A person you name to file for you can file. If you want someone to file for you, you must complete a form that names someone to act for you. You can get this form from the Member Services office at your local *Kaiser Permanente plan facility* or by calling our Member Service Call

Center. This form must be included with your *grievance*.

- You can file for a dependent child, under age 18 (if the child has a legal right to control who sees facts related to the *grievance*, the child must name you to act for him or her).
- You can file for your ward if you are a court-appointed guardian (if the child has a legal right to control who sees facts related to the *grievance*, the child must name you to act for him or her).
- You can file for a conservatee if you are a court-appointed conservator.
- You can file for your principal if you are an agent under a health care proxy (as allowed by law).
- Your doctor can request a faster *grievance* decision as described under "Faster (Expedited) Process" above.

The *L.A. Care* Grievance Process

You can file a *grievance* through *L.A. Care* instead of through *Kaiser Permanente*. To do this, call *L.A. Care* Member Services toll free at **1-888-839-9909,** or write to them at:

L.A. Care Health Plan
1055 W. 7th St., 10th Floor
Los Angeles, CA 90017

L.A. Care will work with you and *Kaiser Permanente* to solve the problem. To learn more about the *L.A. Care grievance* process, or to get a *grievance* form, call *L.A. Care*.

State Hearing

Standard Process

A *state hearing* is a way to solve problems where you present your case to the state. To ask for a *state hearing*, call the California Department of Social Services toll free at **1-800-952-5253** (TTY users call **1-800-952-8349**), or write to them at:

California Department of
Social Services
State Hearing Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244

You have 90 days to ask for a *state hearing* from the date of the incident. You can ask for a *state hearing* at any time during this 90-day period, including before, during, or after you file a *grievance*. You will have a chance to present your side of the case. Once the judge decides the case, you cannot ask for *binding arbitration.* If you ask for a *state hearing*, you may not be able to get an *independent medical review* later.

Faster (Expedited) Process

You or your doctor can ask the state to decide your *state hearing* request faster if it involves imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major body function. To ask for a faster decision, call the California Department of Social Services toll free at **1-800-952-5253** (TTY users call **1-800-952-8349**), or write to them at:

California Department of
Social Services
Expedited Hearings Unit
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244

California Department of Managed Health Care Complaints

The *California Department of Managed Health Care* (*DMHC*) regulates health care service plans. If you have a *grievance* against us, you should first call us toll free at **1-800-464-4000.** *Members* with hearing and speech loss may call the TTY line toll free at **1-800-777-1370**. Use our *grievance* process before you call *DMHC*. Using the *grievance* process does not take away any legal rights or remedies that may be present and ready for you to use. You may call *DMHC* for help with:

- A complaint that has to do with an emergency.
- A complaint that has not been resolved by your health plan in a way that you are happy with.
- A complaint that has remained unresolved for more than 30 days.

You may also be eligible for an *independent medical review* (*IMR*). The *IMR* process provides a neutral review of medical decisions made by a health plan about the medical necessity of:

- A proposed *service* or treatment.
- Coverage decisions for treatments that are *experimental or investigational* in nature.
- Payment disputes for emergency or urgent medical *services*.

To learn more, you may call the *DMHC* toll-free at **1-888-HMO-2219.** *Members* with hearing loss may call the TTY line at **1-877-688-9891.** The *DMHC*'s Internet website, **http://www.hmohelp.ca.gov,** has complaint forms, *IMR* application forms, and instructions online.

Independent Medical Review

You (or someone you name to act for you) can ask for an *independent medical review* (*IMR*) of your issue. This process is managed by the *California Department of Managed Health Care*. They determine which cases qualify for this review. This review is at no cost to you. If you decide not to ask for this review, you may give up the right to pursue some legal actions against us.

You may qualify for an *independent medical review* if:

- One of these situations applies to you:
  - your provider has decided that your *service*s are *medically necessary services*; or

- you got *emergency services* or *urgent care* from a provider who found that *services* were *medically necessary*; or
- you have been seen by a *Kaiser Permanente plan provider* for the diagnosis or treatment of your medical condition; and

- Your request for us to pay for or provide *services* has been denied, changed, or delayed because the *service* was found to be not *medically necessary;* and
- You have filed a *grievance* and we have denied it, or we have not made a decision about your *grievance* within 30 days (or three days for expedited *grievances*). You must first file a *grievance* with us. However, in some cases you can file for an *IMR* before filing a *grievance*. The *California Department of Managed Health Care* may allow you to file an *IMR* case if the problem needs to be taken care of quickly, such as severe pain or potential loss of life, limb, or major body function.

You may also qualify for an *independent medical review* if the *services* you are asking for have been denied as *experimental or investigational* as described under "Experimental or Investigational Denials."

If the *California Department of Managed Health Care* finds that your case is eligible for an *independent medical review,* they will let us know to send your case to their reviewer. Note: You may not be able to ask for an *independent medical review* if you have asked for a *state hearing.*

The *California Department of Managed Health Care* will let you know of the decision when they get it from their reviewer. If the decision is in your favor, we will contact you to arrange for *services* or payment.

Experimental or Investigational Denials

If we deny a *service* because it is *experimental or investigational*, we will let you know in writing. We will tell you within five days of when we made our decision. We will also tell you why we denied the *service* and other ways to solve the problem.

The letter will tell you your right to ask for an *independent medical review* if we had the following facts when we made our decision:

- The doctor who is treating you gave us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be right for you, or that there is no more beneficial standard therapy we cover than the therapy being asked for:
  - "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or

conditions with potentially fatal outcomes where the end point of clinical intervention is survival.
    - "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
- If the doctor who is treating you is a *Kaiser Permanente plan doctor*, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the therapy being asked for is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the *Kaiser Permanente plan doctor* in certifying his or her recommendation.
- You (or your *non–Kaiser Permanente plan doctor* who is a licensed, and either board-certified or board-eligible, doctor qualified in the area of practice appropriate to treat your condition) requested a therapy that is based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The doctor's certification included a statement of evidence relied upon by the doctor in certifying his or her recommendation. We do not cover the *services* of the *non–Kaiser Permanente plan provider.*

You can ask for an *independent medical review* for *experimental or investigational* denials at any time without first filing a *grievance* with us.

Binding Arbitration

Binding arbitration is a way to solve problems using a neutral third party. This third party hears both sides of the issue and makes a decision that both sides must accept. Both sides give up the right to a jury or court trial.

We will use *binding arbitration* to settle claims that we filed before the effective date of this *Member Handbook*. The use of *binding arbitration* for these past claims is binding only on us.

Scope of Arbitration

You must use *binding arbitration* if the claim is related to this *Member Handbook* or your membership with us, if:

- The claim is for:
    - malpractice (a claim that medical *services* or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered); or
    - delivery of *services* or items; or
    - premises liability.
- The claim is brought by:
    - you against us; or
    - us against you.

- The claim cannot be settled through Small Claims Court.

Keep in mind:

- You do not have to use *binding arbitration* for claims that can be settled through a *state hearing*.
- You cannot use *binding arbitration* if you have gotten a decision on the claim through a *state hearing*.

In this "*Binding Arbitration*" section only, "you" means the party who is asking for *binding arbitration:*

- You (a *member*)
- Your heir, relative, or someone you name to act for you
- Someone who claims that a duty to them exists due to your relationship with us

In this "*Binding Arbitration*" section only, "us" means the party who has a claim filed against them:

- *Kaiser Foundation Health Plan, Inc.* ("KFHP")
- Kaiser Foundation Hospitals ("KFH")
- Southern California Permanente Medical Group ("SCPMG")
- The Permanente Medical Group, Inc. ("TPMG")
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any SCPMG or TPMG doctor
- Any person or organization with a contract with any of these parties that requires the use of *binding arbitration*
- Any employee or agent of any of these parties

How to Ask for Arbitration

To ask for *binding arbitration*, you must make a formal request (a Demand for Arbitration), which includes:

- Your description of the claim against us.
- The amount of damages you are asking for.
- The names, addresses, and phone numbers of all the parties who are making the claim. If any of these parties have a lawyer, include the name, address, and phone number of the lawyer.
- The names of the parties who you are filing the claim against.

All claims resulting from the same incident should be included in one request.

Serving the Demand for Arbitration

If you are filing a claim against KFHP, KFH, SCPMG, TPMG, The Permanente Federation, LLC, or The Permanente Company, LLC, mail the Demand for Arbitration to:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

If you are filing a claim against any other party, you must give them notice as required by the California Code of Civil Procedure for a civil action.

We are served when we get the Demand for Arbitration.

Filing Fee

The cost of *binding arbitration* includes a filing fee of $150 that will be waived if you cannot pay your share of the costs.

The filing fee is payable to "Arbitration Account" and is the same amount, no matter how many claims are in your request or the number of parties named, and is not refundable.

If you are not able to pay your share of the costs of *binding arbitration*, you can ask the Office of the Independent Administrator to waive the costs. To do this, you must fill out and send in a Fee Waiver Form to:

- The Office of the Independent Administrator; and
- The parties you are filing the claim against.

The Fee Waiver Form:

- Tells you how the Independent Administrator decides whether to waive the fees.
- Tells you the fees that can be waived.

You can get a copy of the Fee Waiver Form from our Member Service Call Center.

Number of Arbitrators

Some cases are heard by one arbitrator that both sides agree on (a neutral arbitrator). In other cases, each side chooses their own arbitrator (a party arbitrator) in addition to the neutral arbitrator. The number of arbitrators may affect whether we pay the cost of the neutral arbitrator.

If you are asking for damages of $200,000 or less:

- Your case will be heard by one neutral arbitrator.
- If the parties agree in writing, the case will be heard by two party arbitrators and one neutral arbitrator.
- The neutral arbitrator cannot award damages of more than $200,000.

If you are asking for damages of more than $200,000:

- The case must be heard by one neutral arbitrator and two party arbitrators.
- Parties who are entitled to select a party arbitrator may agree to waive this right.
- If all parties agree, these arbitrations will be heard by a neutral arbitrator.

Arbitrators' Fees and Expenses

- We will pay the fees of the neutral arbitrator in some cases. To learn more, look in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the*

Office of the Independent Administrator (Rules of Procedure). You can get a copy of the Rules of Procedure from our Member Service Call Center.

- In all other cases, this cost is shared equally by both parties.

If the parties select party arbitrators, each party pays the fees of their party arbitrator.

Costs

Except as set forth above and as allowed by law, each party must pay their own costs of the *binding arbitration*, no matter the outcome, such as lawyers' fees, witness fees, and other costs.

Rules of Procedure

Binding arbitrations are conducted using the Rules of Procedure:

- The Rules of Procedure were developed by the Office of the Independent Administrator with input from *Kaiser Permanente* and from the Arbitration Advisory Committee.
- You can get a copy of the Rules of Procedure from our Member Service Call Center.

General Provisions

You cannot ask for *binding arbitration* if the claim would not meet the statute of limitations for that claim in a civil action.

Your claim will be dismissed if either:

- You have not acted on it with reasonable diligence in accord with the Rules of Procedure; or
- The hearing has not occurred and more than five years have passed after the earlier of:
  - the date you served the Demand for Arbitration; or
  - the date you filed a civil action based on the same incident.

A claim may be dismissed on other grounds by the neutral arbitrator. Good cause must be shown for this to happen.

If one of the parties does not attend the hearing, the neutral arbitrator may decide the case in that party's absence.

The California Medical Injury Compensation Reform Act (and any amendments) applies to claims as allowed by law, such as:

- The right to introduce evidence of any insurance or disability benefit payment to you.
- Limits on the amount of money you can recover for noneconomic losses.
- The right to have an award for future damages made in periodic payments.

Arbitrations are governed by this "*Binding Arbitration*" section. These standards also apply as long as they do not conflict with this section:

- Section 2 of the Federal Arbitration Act

- The California Code of Civil Procedure
- The Rules of Procedure

California Department of Health Care Services Office of the Ombudsman

You can call the *California Department of Health Care Services* Office of the Ombudsman toll free at **1-888-452-8609** if:

- You have a complaint about *Kaiser Permanente* and cannot get help through:
  - our Member Service Call Center; or
  - *L.A. Care* Member Services toll free at **1-888-839-9909.**
- You want to change health plans and cannot get help through *Health Care Options* toll free at **1--800-430-4263.**

Medi-Cal Fraud

To report *Medi-Cal* fraud, call the *California Department of Health Care Services* toll free at **1-800-822-6222.** You do not have to give your name.

Some examples of fraud are:

- Someone says that you will lose your *Medi-Cal* coverage if you do not transfer to a different *Medi-Cal* provider.
- A *Medi-Cal* provider charges you a *copay* for covered *services*.
- Someone takes your *Medi-Cal* ID card and uses it to get *services*.

How Your Coverage Can End

This section tells you how your coverage with us can end. Once your coverage ends, we will bill you for *services* that you get from *Kaiser Permanente.*

Changing to a Different *L.A. Care Plan Partner*

You Can Change Plan Partners

You can change to a different *L.A. Care* plan partner at any time. *L.A. Care's* other plan partners are Anthem Blue Cross, Care 1st Health Plan, and *L.A. Care Health Plan*. To change plan partners, call *L.A. Care* Member Services toll free at **1-888-839-9909.** Ask to change to a different *L.A. Care* plan partner. This change will not happen right away. Most of the time, it will happen on the first of the next month. *L.A. Care* will let you know when your new coverage starts. Until then, you must get *services* from *Kaiser Permanente.*

You Must Change Plan Partners

You must change to a different *L.A. Care* plan partner if:

- You want to get your health care at a *Federally Qualified Health Center* (*FQHC*) on a regular basis.
- You want to choose a *non–Kaiser Permanente plan provider* as your *PCP* (*Primary Care Provider*).
- Our contract with *L.A. Care* ends.
- You move out of the *Kaiser Permanente service area*.

Disenrolling from *L.A. Care*

You Can Disenroll

You can disenroll from *L.A. Care* at any time if:

- You want to get health care from a different *Medi-Cal* health plan.
- You are a Native American and want to get your health care at an *Indian Health Center* clinic on a regular basis.
- You were enrolled with *L.A. Care* by mistake.
- You are a new *member* with a complex medical condition and you want to go back to your old provider.
- You are in the Foster Care/Adoption Assistance Program.

To disenroll, call *Health Care Options* toll free at **1-800-430-4263.** When you disenroll from *L.A. Care*, *Kaiser Permanente* will no longer be your plan partner.

Note: People with some aid codes must get *services* from a *Medi-Cal managed care* health plan. If you have one of these aid codes, you must get an approval from the *California Department of Health Care Services*

to go back to *regular Medi-Cal.* To learn more, call *Health Care Options* toll free at **1-800-430-4263** or the *California Department of Health Care Services* Office of the Ombudsman toll free at **1-888-452-8609.**

You Must Disenroll

You will be disenrolled from *L.A. Care* if:

- You move out of the *L.A. Care service area*.
- You no longer qualify for *Medi-Cal*.
- You are enrolled in another managed care plan.
- You are in jail.
- *L.A. Care's* contract with the *California Department of Health Care Services* ends.

You will be disenrolled from *L.A. Care* if you need certain *services* that *L.A. Care* does not cover:

- Certain waiver program *services*
- *Services* in a *skilled nursing facility*, intermediate care facility, or subacute care facility after the month of admission plus the next month
- Transplant *services*, except corneal transplants and kidney transplants that *California Children's Services* does not cover

Kaiser Permanente will cover *services* up to the date of disenrollment. When you are disenrolled from *L.A. Care*, *Kaiser Permanente* will no longer be your health care provider. *Health Care Options* will let you know the date your coverage with *L.A. Care* ends. It will take up to 45 days for your coverage to end.

Faster (Expedited) Disenrollment

Health Care Options may disenroll you faster (within 72 hours) if:

- You were enrolled with *L.A. Care* by mistake.
- You need certain *services* that are not covered by *L.A. Care* (like a transplant or care in a *skilled nursing facility*).
- You are in the Foster Care/Adoption Assistance Program.
- You are a new *member* with a complex medical condition and you want to go back to your old provider.

Kaiser Permanente will cover *services* up to the date of disenrollment. *Health Care Options* will let you know the date your coverage with *L.A. Care* ends.

Reassignment for Cause

We can ask *L.A. Care* to assign you to a different *L.A. Care* plan partner if you and your *PCP* (*Primary Care Provider*) cannot get along. For example, you repeatedly do not:

- Follow the care plan you and your *PCP* agree to
- Keep appointments

We can also ask *L.A. Care* to assign you to a different plan partner if:

- Your behavior threatens the safety of *Kaiser Permanente* staff or of any person or property at a *Kaiser Permanente plan facility*.
- You commit theft from *Kaiser Foundation Health Plan, Inc.,* a *Kaiser Permanente plan provider*, or a *Kaiser Permanente plan facility*.
- You intentionally commit fraud, such as presenting a prescription that is not valid or letting someone else use your *Medi-Cal* or *Kaiser Permanente* ID card.

We will report fraud to *L.A. Care.*

We can also ask *L.A. Care* to assign you to a different plan partner if you keep going to a *non–Kaiser Permanente plan provider* for *services* that the *Medical Group* has not *authorized*, except for the following *services* as permitted under this *Member Handbook:*

- Care at a *Federally Qualified Health Center (FQHC)*
- Care at an *Indian Health Center*
- Covered *emergency services* and *post-stabilization care*
- Covered *family planning services*
- Covered *out-of-area urgent care*
- Some covered *sensitive services*

If you are assigned to a different plan partner for cause, you may not be able to enroll with us again in the future.

State Review

If you think that your coverage has ended because of ill health or a request for *services*, you can:

- File a complaint with the *California Department of Managed Health Care* toll free at **1-888-HMO-2219.**
- Call the *California Department of Health Care Services* Office of the Ombudsman toll free at **1-888-452-8609.**

Staying a *Member*

This section tells you ways you can keep your coverage through *Kaiser Permanente* if your coverage with us ends because you no longer qualify for *Medi-Cal*.

Transitional *Medi-Cal* (TMC)

You may be able to keep getting *services* from *Kaiser Permanente* through *L.A. Care* under TMC. TMC is for people who no longer qualify for *Medi-Cal* due to higher earnings from a job, marriage, or a spouse coming back home. You must have a child in the home to qualify. If you qualify, you can get *Medi-Cal* for up to 12 months. To learn more about TMC, ask your county eligibility worker.

Individual Plan

When your membership under this *Member Handbook* ends, you may be able to enroll in one of our other individual plans. Please call our Member Service Call Center to learn more.

Proof of Coverage

When your *Medi-Cal* coverage ends, the *California Department of Health Care Services* will mail you a letter that shows you were an *L.A. Care member*. You can also ask the County Department of Social Services for this letter at any time. You may need this letter when you apply for other health care coverage.

Other Facts About This Plan

Administration of Your Benefits

You must fill out any forms that we ask for in our normal course of business. Also, we may create standards (policies and procedures) in order to better provide your *services*.

If we make an exception to the terms of this *Member Handbook* for you or someone else, we do not have to do the same for you or someone else in the future.

If we do not enforce part of this *Member Handbook*, this does not mean that we waive the terms of this *Member Handbook*. We have the right to enforce the terms of this *Member Handbook* at any time.

Advance Directives

State law gives you two ways to let people know what kind of care you will get if you are very sick or unconscious:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other kinds of care.
- *Individual health care instructions* let you tell people if you want to have life support and other care. You can tell your doctor what you want, and your doctor will write this in your chart. Or, you can write down what you want and have this included in your chart.

To learn more about advance directives or to get the forms, contact the Member Services office at your local *Kaiser Permanente plan facility*. See *Your Guidebook* for more information.

Note: Our advance directives policies and procedures are revised as needed to address any changes in applicable law. We will tell you about those changes within 90 days after the date of the change if the changes affect you.

Assignment

You may not give someone the right to benefits or claims related to your coverage with us unless you get our written approval ahead of time.

Changes to This *Member Handbook*

We, with the approval of *L.A. Care*, can make changes to this *Member Handbook* at any time. We will let you know in writing of any changes 30 days before they happen.

Governing Law

The terms of this *Member Handbook* must follow state law, except when federal law takes precedence. If a law says that we must add something to this *Member Handbook*, we and you must comply even if

that provision is not part of this *Member Handbook*.

Health Insurance Counseling and Advocacy Program (HICAP)

This program helps people with *Medicare* and other health insurance concerns. To learn more, call them toll free at **1-800-434-0222** (TTY users call **711**). They will refer you to an office near you. This is a free service provided by the state.

Lawyer and Advocate Fees and Costs

In any dispute between you and us, the *Medical Group,* or Kaiser Foundation Hospitals, each party will pay their own fees and costs. These include lawyers' fees and advocates' fees.

Member Handbook Binding on Members

The terms of this *Member Handbook* are binding on you when you choose to enroll in *Kaiser Foundation Health Plan, Inc.,* through *L.A. Care.*

New Technology

Kaiser Permanente looks at and reviews new technologies from time to time. We do this to keep up with changes in medical technology and clinical practice. See *Your Guidebook* for more information.

No Agent

Neither you nor *L.A. Care* is an agent of or represents *Kaiser Foundation Health Plan, Inc.*

Nondiscrimination

We do not discriminate in hiring or in how we provide *services* on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, or physical or mental disability, or genetic information.

Notices

We may send you updates about your health care coverage. We will send this to the most recent address we have for you. If you move or have a new address, let us know your new address as soon as you can by calling our Member Service Call Center. Also, let your county eligibility worker and *L.A. Care* know your new address.

Organ Donations

Every day people get a second chance at life because of donated organs. But more than 90,000 people in the U.S. are still waiting for an organ transplant. Anyone can help save lives and give people a chance to live a normal life by becoming an organ or tissue donor. It is easy to register to be an organ or tissue donor. You can even do it when you renew your driver's license. You can change your mind about being an organ donor at any time. If you

want to learn more about organ or tissue donation, go to **www.organdonor.gov** or **www.donatelifecalifornia.org.**

Other Formats for Members with Disabilities

You can request a copy of this *Member Handbook* in another format. Other formats include Braille, audio, electronic text file, or large print. You can get an alternate format of this *Member Handbook* by calling our Member Service Call Center.

Overpayment Recovery

If we pay a provider too much for *services*, we can ask for money back. We may ask the person who got the payment or whoever must pay for the *services.*

Privacy Practices

Kaiser Permanente will protect the privacy of your *protected health information* (*PHI*). We also require all contracting providers to protect the privacy of your *PHI*. Your *PHI* is individually-identifiable information (oral, written, or electronic) about your health, health care services you received, or payment for your health care.

You can generally see and get a copy of your *PHI,* fix errors or update your *PHI*, and ask us for a list of certain disclosures of your *PHI.*

We may use or let others see your *PHI* for care, health research, payment, or health care operations, such as for research or measuring quality of care and *services*. Also, by law, we may have to give *PHI* to the government or in legal actions.

We will not use or disclose your *PHI* for any other purpose without written authorization from you (or someone you name to act for you), except as described in our *Notice of Privacy Practices* (see below) and *Medi-Cal* privacy rules. You do not have to authorize this other use of your *PHI*.

If you see anyone using your information improperly, contact our Member Service Call Center toll free at **1-800-464-4000** or the *California Department of Health Care Services* Privacy Officer at **1-916-255-5259**. You can also e-mail the *California Department of Health Care Services* at **privacyofficer@dhcs.ca.gov.**

This is only a short summary of some of our key privacy practices. Our *Notice of Privacy Practices* tells you more about our privacy practices and your rights regarding your *PHI*. To get a copy, call our Member Service Call Center. You can also find the notice at your local *Kaiser Permanente plan facility* or by going online at **kp.org**.

Public Policy Committee Participation

The Member Advisory Committee, a subcommittee of the KP Cal, LLC, Board of Directors, provides input and recommendations to the KP Cal Board on

public policy considerations. *Members* chosen to participate on the committee would serve a term of two (2) years. *Members* who are interested in serving on the Member Advisory Committee should send a letter to the managing director at:

Kaiser Foundation Health Plan, Inc.
Health Plan Regulatory Services
Attn: Regulatory Response
P.O. Box 12983
Oakland, CA 94604-2983

How to Reach Us

L.A. Care Health Plan

- Member Services
  (toll free) **1-888-839-9909**

Health Care Options

- Eligibility, Enrollment,
  and Disenrollment
  (toll free) **1-800-430-4263**

Kaiser Permanente

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

See *Your Guidebook* for a detailed phone directory and other helpful information, such as:

- The types of covered *services* that are available from each *Kaiser Permanente plan facility* in your area
- How to use our *services* and make appointments
- Hours of operation
- Appointments and advice phone numbers

You can get a copy of *Your Guidebook* by visiting our website at **kp.org** or by calling our Member Service Call Center.

Member Services

To talk to Member Service staff toll free, call:

- English.....**1-800-464-4000**
- Spanish **1-800-788-0616**
- Chinese dialects.....**1-800-757-7585**
- TTY.....**1-800-777-1370**

For help in other languages, please call our Member Service Call Center toll free at **1-800-464-4000** and ask for an *interpreter*.

Member Outreach

You must choose a *PCP* (*Primary Care Provider*) at a *Kaiser Permanente plan facility* in one of the cities listed below. See the "Kaiser Permanente Plan Facilities" section for addresses of these facilities. To choose a *PCP*, call toll free **1-888-956-1616** (TTY users call **711**).

Tri-Central Area

- Baldwin Park
- Bellflower
- Cudahy
- Diamond Bar
- Downey
- Gardena
- Harbor City
- Long Beach
- Lynwood
- Montebello
- San Dimas
- Torrance

- West Covina
- Whittier

Metro Los Angeles Area

- Culver City
- Glendale
- Inglewood
- Los Angeles (Los Angeles Medical Center, West Los Angeles Medical Center, East Los Angeles Medical Offices, Culver Marina Medical Offices)
- Pasadena

Valleys Area

- Lancaster
- Mission Hills
- Palmdale
- Panorama City
- Santa Clarita
- Simi Valley
- Thousand Oaks
- Woodland Hills

Appointments and Advice

To make an appointment or to talk to a licensed health care professional, call:

Tri-Central Area

Call toll free **1-800-780-1277** (TTY users call **1-800-800-7990**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Baldwin Park
- Diamond Bar
- Montebello
- San Dimas
- West Covina

Call toll free **1-800-780-1230** (TTY users call **1-800-800-7990**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Gardena
- Harbor City
- Long Beach
- Torrance

Call toll free **1-800-823-4040** (TTY users call **1-800-800-7990**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Bellflower
- Cudahy
- Downey
- Lynwood
- Whittier

Metro Los Angeles Area

Call toll free **1-800-954-8000** (TTY users call **711**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Culver City
- Glendale
- Inglewood
- Los Angeles (Los Angeles Medical Center, West Los Angeles Medical Center, East Los Angeles Medical Offices, Culver Marina Medical Offices)

- Pasadena

Valleys Area

Call toll free **1-888-515-3500** (TTY users call **711**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Simi Valley
- Thousand Oaks
- Woodland Hills

Call toll free **1-888-778-5000** (TTY users call **711**) for adult, pediatrics, and Ob/Gyn appointments or advice at *Kaiser Permanente plan facilities* located in:

- Lancaster
- Palmdale
- Panorama City
- Santa Clarita

Health Education

To learn about our *health education* programs, call:

- Baldwin Park **1-866-402-4320**
- Downey **1-866-402-4320**
- Harbor City (Carson Office)..... **1-310-816-5440**
- Lancaster..... **1-866-402-4320**
- Los Angeles (Los Angeles Medical Center) **1-323-783-4472**
- Los Angeles (West Los Angeles Medical Center).....**1-323-857-2412** or **1-323-298-3300**
- Panorama City.....**1-818-375-3018**
- Palmdale.....**1-661-533-7600**
- Santa Clarita **1-866-402-4320**
- Woodland Hills.....**1-866-402-4320**

Authorization for Post-Stabilization Care

If you need to request *authorization* for *post-stabilization care* as described under "*Emergency Services*" in the "*Emergency Services* and *Urgent Care*" section, please call:

- The notification telephone number on your *Kaiser Permanente* ID card; or
- **1-800-225-8883** (TTY users, call **711**)

Help with Claim Forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services

If you need a claim form to request payment or reimbursement for emergency ambulance *services* or for *services* described in "*Emergency Services* and *Urgent Care*" in the "Benefits" section, or if you need help completing the form, you can reach us by calling Member Service or by visiting our website at **kp.org**

To talk to Member Service staff toll free, call:

- English.....**1-800-464-4000**

- Spanish..... **1-800-788-0616**
- Chinese dialects..... **1-800-757-7585**
- TTY..... **1-800-777-1370**

Submitting Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services

If you need to submit a completed claim form for emergency ambulance *services*, or for *services* described in "*Emergency Services* and *Urgent Care*" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

KAISER PERMANENTE®

Member Service Call Center

1-800-464-4000
1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired)
Weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays)

kp.org

SKU 60088921 (04/2012)